TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
441 ...	21	SURG	HAND PROCEDURES FOR INJURIES	.9443	2.2	3.2
442 ...	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.3391	5.4	8.2
443 ...	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC	.9979	2.5	3.4
444 ...	21	MED	TRAUMATIC INJURY AGE >17 W CC	.7225	3.2	4.2
445 ...	21	MED	TRAUMATIC INJURY AGE >17 W/O CC	.5054	2.4	3.0
446 ...	21	MED	*TRAUMATIC INJURY AGE 0–17	.2955	2.4	2.4
447 ...	21	MED	ALLERGIC REACTIONS AGE >17	.5160	1.9	2.5
448 ...	21	MED	*ALLERGIC REACTIONS AGE 0–17	.0972	2.9	2.9
449 ...	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W CC	.8073	2.6	3.7
450 ...	21	MED	POISONING & TOXIC EFFECTS OF DRUGS AGE >17 W/O CC	.4409	1.6	2.1
451 ...	21	MED	*POISONING & TOXIC EFFECTS OF DRUGS AGE 0–17	.2625	2.1	2.1
452 ...	21	MED	COMPLICATIONS OF TREATMENT W CC	1.0135	3.5	5.0
453 ...	21	MED	COMPLICATIONS OF TREATMENT W/O CC	.4998	2.2	2.8
454 ...	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W CC	.8586	3.2	4.6
455 ...	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O CC	.4661	2.0	2.6
456 ...			NO LONGER VALID	.0000	.0	.0
457 ...			NO LONGER VALID	.0000	.0	.0
458 ...			NO LONGER VALID	.0000	.0	.0
459 ...			NO LONGER VALID	.0000	.0	.0
460 ...			NO LONGER VALID	.0000	.0	.0
461 ...	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES.	1.2045	2.4	4.6
462 ...	23	MED	REHABILITATION	1.2426	9.3	11.7
463 ...	23	MED	SIGNS & SYMPTOMS W CC	.6922	3.3	4.3
464 ...	23	MED	SIGNS & SYMPTOMS W/O CC	.4771	2.4	3.1
465 ...	23	MED	AFTERCARE W HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.5777	2.1	3.4
466 ...	23	MED	AFTERCARE W/O HISTORY OF MALIGNANCY AS SECONDARY DIAGNOSIS.	.6777	2.2	3.9
467 ...	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	.5112	2.3	4.1
468 ...			EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	3.6423	9.2	13.0
469 ...			**PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	.0000	.0	.0
470 ...			**UNGROUPABLE	.0000	.0	.0
471 ...	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY.	3.1978	5.0	5.7
472 ...			NO LONGER VALID	.0000	.0	.0
473 ...	17	SURG	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE AGE >17	3.5861	7.6	13.1
474 ...			NO LONGER VALID	.0000	.0	.0
475 ...	04	MED	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT.	3.6949	8.1	11.3
476 ...		SURG	PROSTATIC O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	2.2633	8.4	11.6
477 ...		SURG	NON-EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS.	1.8270	5.4	8.2
478 ...	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.3372	5.0	7.3
479 ...	05	SURG	OTHER VASCULAR PROCEDURES W/O CC	1.4333	2.8	3.6
480 ...	PRE	SURG	LIVER TRANSPLANT	9.5064	14.6	19.2
481 ...	PRE	SURG	BONE MARROW TRANSPLANT	8.7719	24.1	27.1
482 ...	PRE	SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES	3.5738	9.9	12.8
483 ...	PRE	SURG	TRACHEOSTOMY EXCEPT FOR FACE, MOUTH & NECK DIAGNOSES.	15.8415	33.4	40.7
484 ...	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	5.6100	9.0	13.3
485 ...	24	SURG	LIMB REATTACHMENT, HIP AND FEMUR PROC FOR MULTIPLE SIGNIFICANT TRA.	3.0519	7.6	9.4
486 ...	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA.	4.9156	8.1	12.2
487 ...	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA	2.0199	5.5	7.7
488 ...	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE	4.5503	11.6	17.0
489 ...	25	MED	HIV W MAJOR RELATED CONDITION	1.7496	6.0	8.6
490 ...	25	MED	HIV W OR W/O OTHER RELATED CONDITION	.9715	3.7	5.1
491 ...	08	SURG	MAJOR JOINT & LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITY.	1.6661	2.9	3.5
492 ...	17	MED	CHEMOTHERAPY W ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS.	4.2524	10.9	16.1
493 ...	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.8180	4.3	5.7
494 ...	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC	1.0374	2.0	2.5
495 ...	PRE	SURG	LUNG TRANSPLANT	8.5947	13.1	20.3
496 ...	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION	5.5796	7.8	10.0
497 ...	08	SURG	SPINAL FUSION W CC	2.9469	4.9	6.2

TABLE 5.—LIST OF DIAGNOSIS RELATED GROUPS (DRGS), RELATIVE WEIGHTING FACTORS, GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—Continued

DRG	MDC	Type	DRG title	Relative weights	Geometric mean LOS	Arithmetic mean LOS
498 ...	08	SURG	SPINAL FUSION W/O CC	1.9077	2.8	3.4
499 ...	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W CC	1.4590	3.6	4.8
500 ...	08	SURG	BACK & NECK PROCEDURES EXCEPT SPINAL FUSION W/O CC	.9811	2.2	2.7
501 ...	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.6350	8.4	10.6
502 ...	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC	1.4327	4.9	6.0
503 ...	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION	1.2151	3.1	4.0
504 ...	22	SURG	EXTENSIVE 3RD DEGREE BURNS W SKIN GRAFT	12.4664	23.9	30.1
505 ...	22	MED	EXTENSIVE 3RD DEGREE BURNS W/O SKIN GRAFT	2.0389	2.5	4.7
506 ...	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA.	4.4971	13.0	17.6
507 ...	22	SURG	FULL THICKNESS BURN W SKIN GRFT OR INHAL INJ W/O CC OR SIG TRAUMA.	1.8438	6.6	9.2
508 ...	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ W CC OR SIG TRAUMA.	1.3119	5.1	7.2
509 ...	22	MED	FULL THICKNESS BURN W/O SKIN GRFT OR INH INJ W/O CC OR SIG TRAUMA.	.8154	4.1	6.2
510 ...	22	MED	NON-EXTENSIVE BURNS W CC OR SIGNIFICANT TRAUMA	1.4130	5.2	7.9
511 ...	22	MED	NON-EXTENSIVE BURNS W/O CC OR SIGNIFICANT TRAUMA	.6568	3.1	4.5

*MEDICARE DATA HAVE BEEN SUPPLEMENTED BY DATA FROM 19 STATES FOR LOW VOLUME DRGS.
**DRGS 469 AND 470 CONTAIN CASES WHICH COULD NOT BE ASSIGNED TO VALID DRGS.
NOTE: GEOMETRIC MEAN IS USED ONLY TO DETERMINE PAYMENT FOR TRANSFER CASES.
NOTE: ARITHMETIC MEAN IS PRESENTED FOR INFORMATIONAL PURPOSES ONLY.
NOTE: RELATIVE WEIGHTS ARE BASED ON MEDICARE PATIENT DATA AND MAY NOT BE APPROPRIATE FOR OTHER PATIENTS.

TABLE 6A.—NEW DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
007.5	Cyclosporiasis	N	6	182, 183, 184
082.40	Unspecified ehrlichiosis	N	18	423
082.41	Ehrlichiosis Chafiensis (E. Chafiensis)	N	18	423
082.49	Other ehrlichiosis	N	18	423
285.21	Anemia in end-stage renal disease	N	16	395, 396
285.22	Anemia in neoplastic disease	N	16	395, 396
285.29	Anemia of other chronic illness	N	16	395, 396
294.10	Dementia in conditions classified elsewhere without behavioral disturbance	N	19	429
294.11	Dementia in conditions classified elsewhere with behavioral disturbance	N	19	429
372.81	Conjunctivochalasis	N	2	46, 47, 48
372.89	Other disorders of conjunctiva	N	2	46, 47, 48
477.1	Allergic rhinitis, due to food	N	3	68, 69, 70
493.02	Extrinsic asthma, with acute exacerbation	Y	4	96, 97, 98
493.12	Intrinsic asthma, with acute exacerbation	Y	4	96, 97, 98
493.22	Chronic obstructive asthma, with acute exacerbation	Y	4	88
493.92	Unspecified asthma, with acute exacerbation	Y	4	96, 97, 98
494.0	Bronchiectasis without acute exacerbation	N	4	88
494.1	Bronchiectasis with acute exacerbation	Y	4	88
558.3	Allergic gastroenteritis and colitis	N	6	182, 183, 184
600.0	Hypertrophy (benign) of prostate	N	12	348, 349
600.1	Nodular prostate	N	12	348, 349
600.2	Benign localized hyperplasia of prostate	N	12	348, 349
600.3	Cyst of prostate	N	12	348, 349
600.9	Unspecified hyperplasia of prostate	N	12	348, 349
645.10	Post term pregnancy, unspecified as to episode of care or not applicable	N	14	469
645.11	Post term pregnancy, delivered, with or without mention of antepartum condition.	N	14	370, 371, 372, 373, 374, 375
645.13	Post term pregnancy, antepartum condition or complication	N	14	383, 384
645.20	Prolonged pregnancy, unspecified as to episode of care or not applicable	N	14	469
645.21	Prolonged pregnancy, delivered, with or without mention of antepartum condition.	N	14	370, 371, 372, 373, 374, 375
645.23	Prolonged pregnancy, antepartum condition or complication	N	14	383, 384
692.75	Disseminated superficial actinic porokeratosis (DSAP)	N	9	283, 284
707.10	Unspecified ulcer of lower limb	Y	9	263, 264, 271
707.11	Ulcer of thigh	Y	9	263, 264, 271
707.12	Ulcer of calf	Y	9	263, 264, 271
707.13	Ulcer of ankle	Y	9	263, 264, 271
707.14	Ulcer of heel and midfoot	Y	9	263, 264, 271
707.15	Ulcer of other part of foot	Y	9	263, 264, 271
707.19	Ulcer of other part of lower limb	Y	9	263, 264, 271

TABLE 6A.—NEW DIAGNOSIS CODES—Continued

Diagnosis code	Description	CC	MDC	DRG
727.83	Plica syndrome	N	8	248
781.91	Loss of height	N	1	34, 35
781.92	Abnormal posture	N	1	34, 35
781.99	Other symptoms involving nervous and musculoskeletal systems	N	1	34, 35
783.21	Loss of weight	N	10	296, 297, 298
783.22	Underweight	N	10	296, 297, 298
783.40	Unspecified lack of normal physiological development	N	10	296, 297, 298
783.41	Failure to thrive	N	10	296, 297, 298
783.42	Delayed milestones	N	10	296, 297, 298
783.43	Short stature	N	10	296, 297, 298
783.7	Adult failure to thrive	N	10	296, 297, 298
790.01	Precipitous drop in hematocrit	N	16	395, 396
790.09	Other abnormality of red blood cells	N	16	395, 396
792.5	Cloudy (hemodialysis) (peritoneal) dialysis effluent	N	23	463, 464
995.7	Other adverse food reactions, not elsewhere classified	N	21	454, 455
996.87	Complications of transplanted organ, intestine	Y	21	452, 453
V15.01	Allergy to peanuts	N	23	467
V15.02	Allergy to milk products	N	23	467
V15.03	Allergy to eggs	N	23	467
V15.04	Allergy to seafood	N	23	467
V15.05	Allergy to other foods	N	23	467
V15.06	Allergy to insects	N	23	467
V15.07	Allergy to latex	N	23	467
V15.08	Allergy to radiographic dye	N	23	467
V15.09	Other allergy, other than to medicinal agents	N	23	467
V21.30	Unspecified low birth weight status	N	23	467
V21.31	Low birth weight status, less than 500 grams	N	23	467
V21.32	Low birth weight status, 500–999 grams	N	23	467
V21.33	Low birth weight status, 1000–1499 grams	N	23	467
V21.34	Low birth weight status, 1500–1999 grams	N	23	467
V21.35	Low birth weight status, 2000–2500 grams	N	23	467
V26.21	Fertility testing	N	23	467
V26.22	Aftercare following sterilization reversal	N	23	467
V26.29	Other investigation and testing	N	23	467
V42.84	Organ or tissue replaced by transplant, intestines	Y	23	467
V45.74	Acquired absence of organ, other parts of urinary tract	N	23	467
V45.75	Acquired absence of organ, stomach	N	23	467
V45.76	Acquired absence of organ, lung	N	23	467
V45.77	Acquired absence of organ, genital organs	N	23	467
V45.78	Acquired absence of organ, eye	N	23	467
V45.79	Other acquired absence of organ	N	23	467
V49.81	Postmenopausal status (age-related) (natural)	N	23	467
V49.89	Other specified conditions influencing health status	N	23	467
V56.31	Encounter for adequacy testing for hemodialysis	N	11	317
V56.32	Encounter for adequacy testing for peritoneal dialysis	N	11	317
V58.83	Encounter for therapeutic drug monitoring	N	23	465, 466
V67.00	Follow-up examination, following unspecified surgery	N	23	465, 466
V67.01	Following surgery, follow-up vaginal pap smear	N	23	465, 466
V67.09	Follow-up examination, following other surgery	N	23	465, 466
V71.81	Observation for suspected abuse and neglect	N	23	467
V71.89	Observation for other specified suspected conditions	N	23	467
V76.46	Special screening for malignant neoplasms, ovary	N	23	467
V76.47	Special screening for malignant neoplasms, Vagina	N	23	467
V76.50	Special screening for malignant neoplasms, unspecified intestine	N	23	467
V76.51	Special screening for malignant neoplasms, colon	N	23	467
V76.52	Special screening for malignant neoplasms, small intestine	N	23	467
V76.81	Special screening for malignant neoplasms, nervous system	N	23	467
V76.89	Special screening for other malignant neoplasm	N	23	467
V77.91	Screening for lipoid disorders	N	23	467
V77.99	Other and unspecified endocrine, nutritional, metabolic, and immunity disorders.	N	23	467
V82.81	Special screening for osteoporosis	N	23	467
V82.89	Special screening for other specified conditions	N	23	467

TABLE 6B.—NEW PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
39.71	Endovascular implantation of graph in abdominal aorta	Y	5	110, 111
			11	315
			21	442, 443
			24	486
39.79	Other endovascular graft repair of aneurysm	Y	1	1, 2, 3
			5	110, 111
			11	315
			21	442, 443
			24	486
41.07	Autologous hematopoietic stem cell transplant with purging	Y	PRE	481
41.08	Allogeneic hematopoietic stem cell transplant with purging	Y	PRE	481
41.09	Autologous bone marrow transplant with purging	Y	PRE	481
46.97	Transplant of intestine	Y	6	148, 149
			7	201
			17	400, 406, 407
			21	442, 443
			24	486
60.96	Transurethral destruction of prostate tissue by microwave thermotherapy	Y	11	306, 307
			12	336, 337
			UNR	476
60.97	Other transurethral destruction of prostate tissue by other thermotherapy	Y	11	306, 307
			12	336, 337
			UNR	476
99.75	Administration of neuroprotective agent	N		

TABLE 6C.—INVALID DIAGNOSIS CODES

Diagnosis code	Description	CC	MDC	DRG
294.1	Dementia in conditions classified elsewhere	N	19	429
372.8	Other disorders of conjunctiva	N	2	46, 47, 48
494	Bronchiectasis	Y	4	88
600	Hyperplasia of prostate	N	12	348, 349
645.00	Prolonged pregnancy, unspecified as to episode of care or not applicable	N	14	469
645.01	Prolonged pregnancy, delivered, with or without mention of antepartum condition.	N	14	370, 371, 372, 373, 374, 375
645.03	Prolonged pregnancy, antepartum condition or complication	N	14	383, 384
707.1	Ulcer of lower limb, except decubitus	Y	9	263, 264, 271
781.9	Other symptoms involving nervous and musculoskeletal systems	N	1	34, 35
783.2	Abnormal loss of weight	N	10	296, 297, 298
783.4	Lack of expected normal physiological development	N	10	296, 297, 298
790.0	Abnormality of red blood cells	N	16	395, 396
V15.0	Allergy, other than to medicinal agents	N	23	467
V26.2	Investigation and testing	N	23	467
V49.8	Other specified problems influencing health status	N	23	467
V67.0	Follow-up examination following surgery	N	23	465, 466
V71.8	Observation for other specified suspected conditions	N	23	467
V76.8	Special screening for malignant neoplasms, other neoplasm	N	23	467
V77.9	Other and unspecified endocrine, nutritional, metabolic, and immunity disorders.	N	23	467
V82.8	Special screening for other specified conditions	N	23	467

TABLE 6D.—REVISED DIAGNOSIS CODE TITLES

Diagnosis code	Description	CC	MDC	DRG
564.1	Irritable bowel syndrome	N	6	182, 183, 184
V26.3	Genetic counseling and testing	N	23	467
V76.49	Special screening for malignant, other sites	N	23	467

TABLE 6E.—REVISED PROCEDURE CODES

Procedure code	Description	OR	MDC	DRG
41.01	Autologous bone marrow transplant without purging	Y	PRE	481
41.04	Autologous hematopoietic stem cell transplant without purging	Y	PRE	481
41.05	Allogeneic hematopoietic stem cell transplant without purging	Y	PRE	481
86.59	Closure of skin and subcutaneous tissue other sites	N		

TABLE 6F.—ADDITIONS TO THE CC EXCLUSIONS LIST

CCs that are added to the list are in Table 6F—Additions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

*0075	2818	70713	49312	01170	4870	01152	4829
00841	2824	70714	49322	01171	4950	01153	4830
00842	28260	70715	49392	01172	4951	01154	4831
00843	28261	70719	*49391	01173	4952	01155	4838
00844	28262	*4871	49302	01174	4953	01156	4841
00845	28263	4941	49312	01175	4954	01160	4843
00846	28269	*49300	49322	01176	4955	01161	4845
00847	2830	49302	49392	01180	4956	01162	4846
00849	28310	49312	*49392	01181	4957	01163	4847
*01790	28311	49322	49301	01182	4958	01164	4848
4941	28319	49392	49302	01183	4959	01165	485
*01791	2832	*49301	49311	01184	496	01166	486
4941	2839	49302	49312	01185	5060	01170	4870
*01792	2840	49312	49320	01186	5061	01171	4941
4941	2848	49322	49321	01190	5070	01172	4950
*01793	2849	49392	49322	01191	5071	01173	4951
4941	2850	*49302	49391	01192	5078	01174	4952
*01794	2851	49301	49392	01193	5080	01175	4953
4941	*29410	49302	*4940	01194	5081	01176	4954
*01795	2910	49311	01100	01195	515	01180	4955
4941	2911	49312	01101	01196	5160	01181	4956
*01796	2912	49320	01102	01200	5161	01182	4957
4941	2913	49321	01103	01201	5162	01183	4958
*28521	2914	49322	01104	01202	5163	01184	4959
2800	29181	49391	01105	01203	5168	01185	496
2814	29189	49392	01106	01204	5169	01186	5060
2818	2919	*49310	01110	01205	5171	01190	5061
2824	2920	49302	01111	01206	5172	01191	5070
28260	29211	49312	01112	01210	5178	01192	5071
28261	29212	49322	01113	01211	74861	01193	5078
28262	2922	49392	01114	01212	*4941	01194	5080
28263	29281	*49311	01115	01213	01100	01195	5081
28269	29282	49302	01116	01214	01101	01196	515
2830	29283	49312	01120	01215	01102	01200	5160
28310	29284	49322	01121	01216	01103	01201	5161
28311	29289	49392	01122	0310	01104	01202	5162
28319	2929	*49312	01123	11505	01105	01203	5163
2832	29381	49301	01124	11515	01106	01204	5168
2839	29382	49302	01125	1304	01110	01205	5169
2840	29383	49311	01126	1363	01111	01206	5171
2848	29384	49312	01130	481	01112	01210	5172
2849	*29411	49320	01131	4820	01113	01211	5178
2850	2910	49321	01132	4821	01114	01212	74861
2851	2911	49322	01133	4822	01115	01213	*496
*28522	2912	49391	01134	48230	01116	01214	4941
2800	2913	49392	01135	48231	01120	01215	*5061
2814	2914	*49320	01136	48232	01121	01216	4941
2818	29181	49302	01140	48239	01122	0310	*5064
2824	29189	49312	01141	48240	01123	11505	4941
28260	2919	49322	01142	48241	01124	11515	*5069
28261	2920	49392	01143	48249	01125	1304	4941
28262	29211	*49321	01144	48281	01126	1363	*5178
28263	29212	49302	01145	48282	01130	481	49302
28269	2922	49312	01146	48283	01131	4820	49312
2830	29281	49322	01150	48284	01132	4821	49322
28310	29282	49392	01151	48289	01133	4822	49392
28311	29283	*49322	01152	4829	01134	48230	*51889
28319	29284	49301	01153	4830	01135	48231	49302
2832	29289	49302	01154	4831	01136	48232	49312
2839	2929	49311	01155	4838	01140	48239	49322
2840	29381	49312	01156	4841	01141	48240	49392
2848	29382	49320	01160	4843	01142	48241	*5198
2849	29383	49321	01161	4845	01143	48249	49302
2850	29384	49322	01162	4846	01144	48281	49312
2851	*44023	49391	01163	4847	01145	48282	49322
*28529	70710	49392	01164	4848	01146	48283	49392
2800	70711	*49390	01165	485	01150	48284	*5199
2814	70712	49302	01166	486	01151	48289	49302

TABLE 6F.—ADDITIONS TO THE CC EXCLUSIONS LIST—Continued

CCs that are added to the list are in Table 6F—Additions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

49312	*70712	V421
49322	70710	V426
49392	70711	V427
*5583	70712	V4281
00841	70713	V4282
00842	70714	V4283
00843	70715	V4289
00844	70719	V432
00845	*70713	*99689
00846	70710	V4284
00847	70711	*99791
00849	70712	99687
*6000	70713	*99799
5960	70714	99687
5996	70715	*V4284
6010	70719	V4284
6012	*70714	*V4289
6013	70710	V4284
6021	70711	*V429
78820	70712	V4284
78829	70713	
*6001	70714	
5960	70715	
5996	70719	
6010	*70715	
6012	70710	
6013	70711	
6021	70712	
78820	70713	
78829	70714	
*6002	70715	
5960	70719	
5996	*70719	
6010	70710	
6012	70711	
6013	70712	
6021	70713	
78820	70714	
78829	70715	
*6003	70719	
5960	*7078	
5996	70710	
6010	70711	
6012	70712	
6013	70713	
6021	70714	
78820	70715	
78829	70719	
*6009	*7079	
5960	70710	
5996	70711	
6010	70712	
6012	70713	
6013	70714	
6021	70715	
78820	70719	
78829	*7098	
*70710	70710	
70710	70711	
70711	70712	
70712	70713	
70713	70714	
70714	70715	
70715	70719	
70719	*74861	
*70711	4941	
70710	*99680	
70711	99687	
70712	V4284	
70713	*99687	
70714	99680	
70715	99687	
70719	V420	

TABLE 6G.—DELECTIONS TO THE CC EXCLUSIONS LIST

CCs that are deleted from the list are in Table 6G—Deletions to the CC Exclusions List. Each of the principal diagnoses is shown with an asterisk, and the revisions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

*01790	01135	48231	6021
494	01136	48232	78820
*01791	01140	48239	78829
494	01141	48240	*7071
*01792	01142	48241	7071
494	01143	48249	*7078
*01793	01144	48281	7071
494	01145	48282	*7079
*01794	01146	48283	7071
494	01150	48284	*7098
01795	01151	48289	7071
494	01152	4829	*74861
*01796	01153	4830	494
494	01154	4831	
*2941	01155	4838	
2910	01156	4841	
2911	01160	4843	
2912	01161	4845	
2913	01162	4846	
2914	01163	4847	
29181	01164	4848	
29189	01165	485	
2919	01166	486	
2920	01170	4870	
29211	01171	494	
29212	01172	4950	
2922	01173	4951	
29281	01174	4952	
29282	01175	4953	
29283	01176	4954	
29284	01180	4955	
29289	01181	4956	
2929	01182	4957	
29381	01183	4958	
29382	01184	4959	
29383	01185	496	
29384	01186	5060	
*44023	01190	5061	
7071	01191	5070	
*4871	01192	5071	
494	01193	5078	
*494	01194	5080	
01100	01195	5081	
01101	01196	515	
01102	01200	5160	
01103	01201	5161	
01104	01202	5162	
01105	01203	5163	
01106	01204	5168	
01110	01205	5169	
01111	01206	5171	
01112	01210	5172	
01113	01211	5178	
01114	01212	74861	
01115	01213	*496	
01116	01214	494	
01120	01215	*5061	
01121	01216	494	
01122	0310	*5064	
01123	11505	494	
01124	11515	*5069	
01125	1304	494	
01126	1363	*600	
01130	481	5960	
01131	4820	5996	
01132	4821	6010	
01133	4822	6012	
01134	48230	6013	

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY

[FY99 MEDPAR Update 12/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	35069	9.0962	2	4	6	12	19
2	7064	9.6692	3	5	7	12	19
4	6022	7.3316	1	2	5	9	16
5	95151	3.2852	1	1	2	3	7
6	340	3.2412	1	1	2	4	7
7	12054	10.2745	2	4	7	13	21
8	3662	3.0145	1	1	2	4	7
9	1623	6.4898	1	3	5	8	12
10	18297	6.5874	2	3	5	8	13
11	3300	4.1488	1	2	3	5	8
12	44849	6.0417	2	3	4	7	11
13	6185	5.0928	2	3	4	6	9
14	330036	5.9583	2	3	5	7	11
15	139608	3.6293	1	2	3	5	7
16	11101	6.1222	2	3	5	7	12
17	3437	3.3750	1	2	3	4	6
18	25899	5.5415	2	3	4	7	10
19	7951	3.7393	1	2	3	5	7
20	5735	10.2382	3	5	8	13	20
21	1356	6.8754	2	3	5	9	13
22	2501	4.9384	2	2	4	6	9
23	8311	4.2224	1	2	3	5	8
24	52472	5.0144	1	2	4	6	10
25	24380	3.3056	1	2	3	4	6
26	20	3.2000	1	1	2	3	7
27	3567	5.0962	1	1	3	6	11
28	10686	6.2281	1	3	5	8	13
29	3910	3.7133	1	2	3	5	7
31	3209	4.2312	1	2	3	5	8
32	1545	2.7398	1	1	2	3	5
34	19531	5.1937	1	2	4	6	10
35	5177	3.4199	1	2	3	4	6
36	4223	1.3640	1	1	1	1	2
37	1476	3.6917	1	1	3	5	8
38	115	2.5304	1	1	1	3	5
39	1152	1.9106	1	1	1	2	4
40	1755	3.5801	1	1	2	4	8
41	1	4.0000	4	4	4	4	4
42	2698	2.2279	1	1	1	3	5
43	83	3.3012	1	2	3	4	7
44	1226	4.9625	2	3	4	6	9
45	2490	3.2743	1	2	3	4	6
46	2940	4.5871	1	2	4	6	9
47	1183	3.2975	1	1	3	4	6
49	2228	4.9677	1	2	4	6	9
50	2569	1.9844	1	1	1	2	3
51	264	2.5606	1	1	1	3	6
52	196	2.1276	1	1	1	2	5
53	2569	3.6734	1	1	2	4	8
54	4	1.5000	1	1	1	1	3
55	1560	2.8865	1	1	1	3	6
56	526	3.0646	1	1	2	4	6
57	579	3.9862	1	1	2	4	8
59	111	2.4414	1	1	2	2	5
60	2	1.0000	1	1	1	1	1
61	208	4.8894	1	1	2	6	13
62	2	3.5000	2	2	5	5	5
63	3168	4.2601	1	2	3	5	9
64	3162	6.4756	1	2	4	8	14
65	31728	2.8963	1	1	2	4	5
66	6938	3.1721	1	1	3	4	6
67	477	3.5241	1	2	3	4	7
68	13401	4.1595	1	2	3	5	8
69	4228	3.2774	1	2	3	4	6
70	33	2.9091	1	2	3	4	5
71	105	3.8667	1	2	3	6	7
72	812	3.3017	1	2	3	4	6
73	6402	4.3380	1	2	3	5	8
75	39147	9.9967	3	5	8	12	20
76	39851	11.2556	3	5	9	14	21

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR Update 12/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
77	2375	4.8880	1	2	4	7	10
78	30492	6.9444	3	5	6	8	11
79	183121	8.4551	3	4	7	11	16
80	8291	5.6652	2	3	5	7	10
81	5	9.2000	2	2	10	10	19
82	63683	6.9428	2	3	5	9	14
83	6462	5.5305	2	3	4	7	10
84	1494	3.3681	1	2	3	4	6
85	20066	6.3638	2	3	5	8	12
86	1923	3.7889	1	2	3	5	7
87	62959	6.2450	1	3	5	8	12
88	403808	5.2212	2	3	4	7	9
89	524107	6.0245	2	3	5	7	11
90	51271	4.2271	2	3	4	5	7
91	49	3.3061	1	2	3	4	5
92	13763	6.2465	2	3	5	8	12
93	1543	3.9942	1	2	3	5	7
94	12332	6.3027	2	3	5	8	12
95	1561	3.6887	1	2	3	5	7
96	64893	4.7277	2	3	4	6	8
97	31521	3.6879	1	2	3	5	7
98	18	4.6667	1	1	3	6	7
99	18166	3.2204	1	1	2	4	6
100	7230	2.2047	1	1	2	3	4
101	19700	4.4248	1	2	3	5	8
102	4970	2.7360	1	1	2	3	5
103	442	48.6041	9	12	29	64	112
104	33069	11.6306	3	6	10	15	22
105	29348	9.2675	4	5	7	11	17
106	3800	11.2111	5	7	9	13	20
107	90499	10.3531	5	7	9	12	17
108	5234	10.5728	3	5	8	13	20
109	61584	7.7338	4	5	6	9	13
110	54902	9.4567	2	5	8	11	18
111	7109	5.4788	2	4	5	7	8
112	60796	3.7594	1	1	3	5	8
113	44201	12.0562	3	6	9	15	24
114	8478	8.2536	2	4	7	10	16
115	14032	8.4152	1	4	7	11	16
116	308071	3.7287	1	1	3	5	8
117	3404	4.0523	1	1	2	5	9
118	6649	2.8117	1	1	1	3	6
119	1445	4.8374	1	1	3	6	12
120	36651	8.1192	1	2	5	10	18
121	163449	6.4387	2	3	5	8	12
122	80682	3.8317	1	2	3	5	7
123	40870	4.5742	1	1	3	6	11
124	134743	4.3708	1	2	3	6	8
125	74923	2.7862	1	1	2	4	5
126	5131	11.6936	3	6	9	14	22
127	680654	5.3354	2	3	4	7	10
128	11526	5.8044	3	4	5	7	9
129	4173	2.8447	1	1	1	3	7
130	89048	5.8037	2	3	5	7	10
131	26830	4.3785	1	3	4	6	7
132	152932	3.0474	1	1	2	4	6
133	7573	2.3956	1	1	2	3	4
134	32813	3.2987	1	2	3	4	6
135	7100	4.4668	1	2	3	5	9
136	1170	2.9120	1	1	2	4	6
138	191436	4.0071	1	2	3	5	8
139	77194	2.5069	1	1	2	3	5
140	76478	2.7136	1	1	2	3	5
141	85791	3.7068	1	2	3	5	7
142	42652	2.6766	1	1	2	3	5
143	185700	2.1667	1	1	2	3	4
144	78800	5.3171	1	2	4	7	11
145	6884	2.8117	1	1	2	4	6
146	11215	10.1815	5	7	9	12	17
147	2418	6.6208	3	5	6	8	10

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR Update 12/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
148	134272	12.1101	5	7	10	14	22
149	17551	6.6488	4	5	6	8	10
150	20300	11.1450	4	7	9	14	20
151	4479	5.9272	2	3	5	8	10
152	4441	8.1743	3	5	7	10	14
153	1914	5.4713	3	4	5	7	8
154	29346	13.2615	4	7	10	16	25
155	6052	4.3354	1	2	3	6	8
156	2	28.0000	28	28	28	28	28
157	8196	5.4926	1	2	4	7	11
158	4393	2.6271	1	1	2	3	5
159	16421	5.0258	1	2	4	6	10
160	10974	2.7204	1	1	2	4	5
161	11483	4.1695	1	2	3	5	9
162	7018	1.9577	1	1	1	2	4
163	8	2.7500	1	1	3	3	3
164	4720	8.4019	4	5	7	10	15
165	1942	4.8553	2	3	5	6	8
166	3307	5.0889	2	3	4	6	9
167	2896	2.7099	1	2	2	3	5
168	1511	4.5963	1	2	3	6	9
169	802	2.4214	1	1	2	3	5
170	11287	11.1669	2	5	8	14	23
171	1125	4.7911	1	2	4	6	9
172	30485	6.9710	2	3	5	9	14
173	2492	3.8435	1	1	3	5	8
174	236408	4.8222	2	3	4	6	9
175	28026	2.9414	1	2	3	4	5
176	15607	5.2668	2	3	4	6	10
177	9489	4.5521	2	2	4	6	8
178	3568	3.1373	1	2	3	4	6
179	12177	6.0139	2	3	5	7	11
180	85083	5.3978	2	3	4	7	10
181	24320	3.4134	1	2	3	4	6
182	232501	4.3626	1	2	3	5	8
183	78432	2.9618	1	1	2	4	6
184	98	3.2449	1	2	2	4	5
185	4300	4.4963	1	2	3	6	9
186	2	4.5000	2	2	7	7	7
187	722	3.8130	1	2	3	5	8
188	74594	5.5723	1	2	4	7	11
189	11097	3.1388	1	1	2	4	6
190	69	6.0290	2	3	4	6	11
191	9367	14.0878	4	7	10	18	28
192	974	6.5842	2	4	6	8	11
193	5669	12.5490	5	7	10	15	23
194	755	6.7497	2	4	6	8	12
195	4869	9.9029	4	6	8	12	17
196	1190	5.6832	2	4	5	7	9
197	20225	8.7363	3	5	7	11	16
198	6079	4.4996	2	3	4	6	8
199	1724	9.6456	3	4	8	12	19
200	1071	10.7404	2	4	8	14	22
201	1465	13.8314	3	6	11	18	27
202	25595	6.5031	2	3	5	8	13
203	28958	6.6940	2	3	5	9	13
204	54818	5.8581	2	3	4	7	11
205	22519	6.2964	2	3	5	8	12
206	1778	3.8335	1	2	3	5	7
207	30768	5.1176	1	2	4	6	10
208	9616	2.8974	1	1	2	4	6
209	342301	5.1232	3	3	4	6	8
210	126555	6.8082	3	4	6	8	11
211	31227	4.9152	3	4	4	6	7
212	7	3.0000	2	2	2	3	4
213	8882	8.7299	2	4	7	11	17
216	5822	9.7583	2	4	7	12	19
217	17573	13.0833	3	5	9	16	28
218	21344	5.3594	2	3	4	6	10
219	19125	3.2444	1	2	3	4	5

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR Update 12/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
220	2	2.5000	1	1	4	4	4
223	17434	2.5812	1	1	2	3	5
224	7953	2.0448	1	1	2	3	4
225	5575	4.7146	1	2	3	6	10
226	4985	6.2828	1	2	4	8	13
227	4416	2.6594	1	1	2	3	5
228	2437	3.5568	1	1	2	4	8
229	1080	2.3944	1	1	2	3	5
230	2102	5.1237	1	2	3	6	10
231	10618	4.8282	1	2	3	6	10
232	565	3.5894	1	1	2	4	9
233	4542	7.6797	2	3	5	9	16
234	2666	3.5709	1	2	3	4	7
235	5334	5.1245	1	2	4	6	10
236	38564	4.8516	1	3	4	6	9
237	1576	3.7386	1	2	3	5	7
238	7594	8.4664	3	4	6	10	16
239	51719	6.2172	2	3	5	8	12
240	11850	6.5754	2	3	5	8	13
241	2953	3.9401	1	2	3	5	7
242	2477	6.5268	2	3	5	8	12
243	84831	4.7022	1	3	4	6	9
244	11891	4.7802	1	2	4	6	9
245	4929	3.7206	1	2	3	4	7
246	1342	3.6461	1	2	3	4	7
247	15047	3.4443	1	1	3	4	7
248	9336	4.7321	1	2	4	6	9
249	10719	3.7768	1	1	3	5	8
250	3509	4.2485	1	2	3	5	8
251	2351	2.9872	1	1	3	4	5
252	1	2.0000	2	2	2	2	2
253	18878	4.6841	1	3	4	6	9
254	10341	3.2080	1	2	3	4	6
255	1	1.0000	1	1	1	1	1
256	5803	5.1260	1	2	4	6	10
257	16795	2.8263	1	2	2	3	5
258	15710	2.0006	1	1	2	2	3
259	3717	2.7896	1	1	1	3	6
260	4780	1.4749	1	1	1	2	2
261	1730	2.1624	1	1	1	2	4
262	673	3.8098	1	1	3	5	7
263	24527	11.5534	3	5	8	14	23
264	3877	6.9010	2	3	5	8	14
265	3868	6.6099	1	2	4	8	14
266	2527	3.3174	1	1	2	4	7
267	255	5.2353	1	1	3	6	12
268	896	3.6953	1	1	2	4	8
269	8856	8.2516	2	3	6	10	16
270	2734	3.2579	1	1	2	4	7
271	21090	7.1019	2	4	6	8	13
272	5465	6.3420	2	3	5	8	12
273	1341	4.2118	1	2	3	5	8
274	2368	6.9548	2	3	5	9	14
275	224	3.3125	1	1	2	4	7
276	1076	4.6515	1	2	4	6	9
277	83707	5.7178	2	3	5	7	10
278	28524	4.3359	2	3	4	5	7
279	4	4.0000	2	2	4	5	5
280	15047	4.1980	1	2	3	5	8
281	6682	3.0805	1	1	3	4	6
283	5322	4.5569	1	2	3	6	9
284	1852	3.1960	1	1	2	4	6
285	6125	10.4263	3	5	8	13	20
286	1995	6.2000	2	3	5	7	11
287	5974	10.5387	3	5	8	13	20
288	2252	5.7234	2	3	4	6	9
289	4326	3.1248	1	1	2	3	7
290	8214	2.4329	1	1	2	2	4
291	57	1.6316	1	1	1	2	2
292	4945	9.9610	2	4	7	13	21

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR Update 12/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
293	321	4.9346	1	2	4	7	10
294	83924	4.7128	1	2	4	6	9
295	3464	3.8467	1	2	3	5	7
296	232274	5.2398	2	3	4	6	10
297	40842	3.4744	1	2	3	4	6
298	106	3.1887	1	2	2	4	6
299	1052	5.5542	1	2	4	6	11
300	15582	6.1317	2	3	5	8	12
301	3101	3.7004	1	2	3	5	7
302	7525	9.4141	4	5	7	11	16
303	19405	8.4850	4	5	7	10	15
304	11967	8.8979	2	4	7	11	18
305	2852	3.8443	1	2	3	5	7
306	7925	5.4829	1	2	3	7	12
307	2226	2.2668	1	1	2	3	4
308	7673	6.3836	1	2	4	8	14
309	3947	2.4880	1	1	2	3	5
310	23701	4.3591	1	2	3	5	9
311	8200	1.8902	1	1	1	2	3
312	1570	4.5166	1	1	3	6	10
313	633	2.1153	1	1	1	3	4
314	2	1.0000	1	1	1	1	1
315	28524	7.4721	1	1	5	10	17
316	96406	6.6791	2	3	5	8	13
317	1230	3.2114	1	1	2	3	6
318	5544	5.9975	1	3	4	7	12
319	460	2.8630	1	1	2	4	6
320	181708	5.3834	2	3	4	7	10
321	28174	3.8452	1	2	3	5	7
322	69	4.0580	1	2	3	5	7
323	16353	3.2183	1	1	2	4	7
324	7365	1.8789	1	1	1	2	3
325	7788	3.8947	1	2	3	5	7
326	2414	2.6582	1	1	2	3	5
327	7	9.2857	1	1	2	4	13
328	718	3.9053	1	1	3	5	8
329	104	2.0481	1	1	1	3	4
331	43233	5.5300	1	2	4	7	11
332	4795	3.2715	1	1	2	4	7
333	296	5.0507	1	2	3	6	10
334	12132	4.8938	2	3	4	6	8
335	11393	3.4104	2	3	3	4	5
336	40525	3.5229	1	2	3	4	7
337	30540	2.1759	1	1	2	3	3
338	1641	5.2956	1	2	3	7	12
339	1503	4.5269	1	1	3	6	10
340	1	1.0000	1	1	1	1	1
341	3836	3.2018	1	1	2	3	7
342	775	3.1174	1	2	2	4	6
344	3934	2.2567	1	1	1	2	4
345	1272	3.7673	1	1	2	5	8
346	4622	5.8090	1	3	4	7	11
347	396	3.3712	1	1	2	4	7
348	3105	4.2029	1	2	3	5	8
349	589	2.6027	1	1	2	3	5
350	6157	4.3937	2	2	4	5	8
352	646	3.8498	1	2	3	5	8
353	2631	6.7081	3	3	5	8	13
354	8209	5.8725	3	3	4	7	10
355	5698	3.3243	2	3	3	4	5
356	25961	2.4179	1	1	2	3	4
357	5767	8.4947	3	4	7	10	16
358	21628	4.3926	2	3	3	5	7
359	29103	2.8141	2	2	3	3	4
360	16133	2.9634	1	2	2	3	5
361	420	3.4524	1	1	2	4	7
362	1	1.0000	1	1	1	1	1
363	3079	3.4784	1	2	2	3	7
364	1611	3.5847	1	1	2	5	7
365	1917	7.3005	2	3	5	9	16

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR Update 12/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
366	4226	6.7283	1	3	5	8	14
367	472	3.1462	1	1	2	4	7
368	2861	6.7113	2	3	5	8	13
369	2832	3.1963	1	1	2	4	6
370	1141	5.7160	3	3	4	5	9
371	1174	3.6567	2	3	3	4	5
372	916	3.4509	2	2	2	3	5
373	3916	2.2829	1	2	2	2	3
374	125	3.4880	2	2	2	3	5
375	6	2.6667	2	2	2	3	3
376	254	3.4803	1	2	2	4	7
377	53	3.8679	1	1	2	5	8
378	151	2.3444	1	1	2	3	4
379	355	3.1127	1	1	2	3	7
380	74	2.1622	1	1	2	2	4
381	176	1.9545	1	1	1	2	3
382	39	1.3077	1	1	1	1	2
383	1545	3.8913	1	1	3	5	8
384	123	2.3415	1	1	1	2	4
389	8	5.8750	3	3	4	8	10
390	19	3.7368	1	1	3	5	7
392	2508	9.4769	3	4	7	12	19
393	1	8.0000	8	8	8	8	8
394	1724	6.6810	1	2	4	8	15
395	80464	4.5303	1	2	3	6	9
396	17	3.7059	1	1	2	5	6
397	18071	5.2277	1	2	4	7	10
398	18051	5.9638	2	3	5	7	11
399	1614	3.5520	1	2	3	4	7
400	6845	9.0488	1	3	6	12	20
401	5827	11.1903	2	5	8	14	23
402	1483	3.9400	1	1	3	5	8
403	33277	8.0524	2	3	6	10	17
404	4491	4.2224	1	2	3	6	9
406	2546	10.2859	3	4	7	13	21
407	695	4.4086	1	2	4	6	8
408	2246	7.7061	1	2	5	10	18
409	3281	5.9113	2	3	4	6	11
410	40863	3.7201	1	2	3	5	6
411	13	2.3077	1	1	2	4	4
412	29	2.7241	1	1	2	3	6
413	6149	7.2477	2	3	6	9	14
414	712	4.0941	1	2	3	5	9
415	39856	14.1713	4	6	11	18	28
416	195783	7.3483	2	4	6	9	14
417	32	6.1875	1	2	4	7	13
418	22097	6.1239	2	3	5	7	11
419	15859	4.8212	2	2	4	6	9
420	3091	3.5642	1	2	3	4	6
421	12242	3.8638	1	2	3	5	7
422	96	5.2708	1	2	2	5	7
423	8073	8.1416	2	3	6	10	17
424	1354	13.3936	2	5	9	16	28
425	15006	4.0716	1	2	3	5	8
426	4313	4.5613	1	2	3	6	9
427	1660	5.0283	1	2	3	6	10
428	839	7.1025	1	2	4	8	15
429	27480	6.4737	2	3	5	8	12
430	58011	8.2066	2	3	6	10	16
431	295	6.5864	2	3	5	8	13
432	389	4.7506	1	2	3	5	9
433	5781	3.0073	1	1	2	4	6
434	21835	5.0844	1	2	4	6	9
435	14486	4.2925	1	2	4	5	8
436	3499	12.8337	4	7	11	17	25
437	9750	8.9544	3	5	8	11	15
439	1287	8.1756	1	3	5	10	17
440	5017	8.8433	2	3	6	10	19
441	579	3.2383	1	1	2	4	7
442	15896	8.2292	1	3	6	10	17

TABLE 7A.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR Update 12/99 Grouper V17.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
443	3547	3.3941	1	1	2	4	7
444	5150	4.2252	1	2	3	5	8
445	2223	3.0031	1	1	2	4	5
447	4854	2.5117	1	1	2	3	5
448	1	4.0000	4	4	4	4	4
449	26543	3.6722	1	1	3	4	7
450	6363	2.0525	1	1	1	2	4
451	1	1.0000	1	1	1	1	1
452	21656	4.9536	1	2	3	6	10
453	4464	2.8156	1	1	2	3	5
454	4930	4.5554	1	2	3	6	9
455	1070	2.6262	1	1	2	3	5
461	3356	4.5584	1	1	2	5	11
462	12630	11.5264	4	6	9	15	21
463	18895	4.2653	1	2	3	5	8
464	5456	3.0770	1	1	2	4	6
465	227	3.3612	1	1	2	3	7
466	1719	3.8674	1	1	2	4	8
467	1301	4.0638	1	1	2	4	7
468	58386	12.9325	3	6	10	17	26
471	11423	5.7339	3	4	5	6	9
473	7615	12.8411	2	3	7	19	32
475	109114	11.1765	2	5	9	15	22
476	4448	11.6369	2	5	10	15	21
477	25690	8.1425	1	3	6	10	17
478	111192	7.3159	1	3	5	9	15
479	22375	3.6220	1	2	3	5	7
480	460	19.1848	7	9	14	23	38
481	229	27.1485	16	19	23	32	43
482	6119	12.7756	4	7	10	15	24
483	43070	38.8321	14	21	32	49	70
484	323	13.3065	2	5	10	18	28
485	2932	9.3905	4	5	7	11	17
486	2012	12.1511	1	5	9	16	24
487	3491	7.5408	1	3	6	10	15
488	767	16.9465	4	7	12	21	34
489	14253	8.5597	2	3	6	10	18
490	5283	5.1333	1	2	4	6	10
491	11332	3.4896	2	2	3	4	6
492	2667	16.1234	4	5	9	26	34
493	54030	5.7170	1	3	5	7	11
494	27254	2.4838	1	1	2	3	5
495	145	20.2552	6	8	12	18	33
496	1270	9.9843	4	5	7	12	18
497	22593	6.2173	2	3	5	7	11
498	19133	3.4179	1	2	3	4	6
499	30738	4.7687	1	2	4	6	9
500	42090	2.6897	1	1	2	3	5
501	1943	10.5713	4	5	8	13	20
502	612	5.9379	2	3	5	7	10
503	5563	3.9730	1	2	3	5	7
504	122	30.0984	10	15	25	40	60
505	153	4.7190	1	1	2	6	12
506	962	17.6258	4	8	14	24	37
507	280	9.1857	2	4	7	13	18
508	637	7.1350	2	3	5	9	15
509	165	6.1333	1	2	4	8	12
510	1653	7.8506	2	3	5	9	17
511	594	4.4646	1	1	3	6	10
	10930692						

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY

[FY99 MEDPAR Update 12/99 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
1	35069	9.0962	2	4	6	12	19

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR Update 12/99 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
2	7064	9.6692	3	5	7	12	19
4	6022	7.3316	1	2	5	9	16
5	95151	3.2852	1	1	2	3	7
6	340	3.2412	1	1	2	4	7
7	12054	10.2745	2	4	7	13	21
8	3662	3.0145	1	1	2	4	7
9	1623	6.4898	1	3	5	8	12
10	18297	6.5874	2	3	5	8	13
11	3300	4.1488	1	2	3	5	8
12	44849	6.0417	2	3	4	7	11
13	6185	5.0928	2	3	4	6	9
14	362463	6.0528	2	3	5	7	11
15	139608	3.6293	1	2	3	5	7
16	11101	6.1222	2	3	5	7	12
17	3437	3.3750	1	2	3	4	6
18	25899	5.5415	2	3	4	7	10
19	7951	3.7393	1	2	3	5	7
20	5735	10.2382	3	5	8	13	20
21	1356	6.8754	2	3	5	9	13
22	2501	4.9384	2	2	4	6	9
23	8311	4.2224	1	2	3	5	8
24	52472	5.0144	1	2	4	6	10
25	24380	3.3056	1	2	3	4	6
26	20	3.2000	1	1	2	3	7
27	3567	5.0962	1	1	3	6	11
28	10685	6.2270	1	3	5	8	13
29	3910	3.7133	1	2	3	5	7
31	3209	4.2312	1	2	3	5	8
32	1545	2.7398	1	1	2	3	5
34	19531	5.1937	1	2	4	6	10
35	5177	3.4199	1	2	3	4	6
36	4223	1.3640	1	1	1	1	2
37	1476	3.6917	1	1	3	5	8
38	115	2.5304	1	1	1	3	5
39	1152	1.9106	1	1	1	2	4
40	1755	3.5801	1	1	2	4	8
41	1	4.0000	4	4	4	4	4
42	2698	2.2279	1	1	1	3	5
43	83	3.3012	1	2	3	4	7
44	1226	4.9625	2	3	4	6	9
45	2490	3.2743	1	2	3	4	6
46	2940	4.5871	1	2	4	6	9
47	1183	3.2975	1	1	3	4	6
49	2228	4.9677	1	2	4	6	9
50	2569	1.9844	1	1	1	2	3
51	264	2.5606	1	1	1	3	6
52	196	2.1276	1	1	1	2	5
53	2569	3.6734	1	1	2	4	8
54	4	1.5000	1	1	1	1	3
55	1560	2.8865	1	1	1	3	6
56	526	3.0646	1	1	2	4	6
57	579	3.9862	1	1	2	4	8
59	111	2.4414	1	1	2	2	5
60	2	1.0000	1	1	1	1	1
61	208	4.8894	1	1	2	6	13
62	2	3.5000	2	2	5	5	5
63	3168	4.2601	1	2	3	5	9
64	3162	6.4756	1	2	4	8	14
65	31728	2.8963	1	1	2	4	5
66	6938	3.1721	1	1	3	4	6
67	477	3.5241	1	2	3	4	7
68	13401	4.1595	1	2	3	5	8
69	4228	3.2774	1	2	3	4	6
70	33	2.9091	1	2	3	4	5
71	105	3.8667	1	2	3	6	7
72	812	3.3017	1	2	3	4	6
73	6402	4.3380	1	2	3	5	8
75	39147	9.9967	3	5	8	12	20
76	39851	11.2556	3	5	9	14	21
77	2375	4.8880	1	2	4	7	10

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR Update 12/99 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
78	30492	6.9444	3	5	6	8	11
79	183121	8.4551	3	4	7	11	16
80	8291	5.6652	2	3	5	7	10
81	5	9.2000	2	2	10	10	19
82	63683	6.9428	2	3	5	9	14
83	6462	5.5305	2	3	4	7	10
84	1494	3.3681	1	2	3	4	6
85	20066	6.3638	2	3	5	8	12
86	1923	3.7889	1	2	3	5	7
87	62959	6.2450	1	3	5	8	12
88	403808	5.2212	2	3	4	7	9
89	524106	6.0245	2	3	5	7	11
90	51271	4.2271	2	3	4	5	7
91	49	3.3061	1	2	3	4	5
92	13763	6.2465	2	3	5	8	12
93	1543	3.9942	1	2	3	5	7
94	12332	6.3027	2	3	5	8	12
95	1561	3.6887	1	2	3	5	7
96	64893	4.7277	2	3	4	6	8
97	31521	3.6879	1	2	3	5	7
98	18	4.6667	1	1	3	6	7
99	18166	3.2204	1	1	2	4	6
100	7230	2.2047	1	1	2	3	4
101	19700	4.4248	1	2	3	5	8
102	4970	2.7360	1	1	2	3	5
103	442	48.6041	9	12	29	64	112
104	33352	11.6423	3	6	10	15	22
105	29488	9.2812	4	5	7	11	17
106	3785	11.2201	5	7	9	13	20
107	90361	10.3492	5	7	9	12	17
108	5213	10.5580	3	5	8	13	20
109	61526	7.7320	4	5	6	9	13
110	54724	9.4413	2	5	8	11	18
111	7102	5.4816	2	4	5	7	8
112	60794	3.7592	1	1	3	5	8
113	49775	12.1191	4	6	9	15	24
114	8478	8.2536	2	4	7	10	16
115	14032	8.4152	1	4	7	11	16
116	308070	3.7287	1	1	3	5	8
117	3404	4.0523	1	1	2	5	9
118	6649	2.8117	1	1	1	3	6
119	1445	4.8374	1	1	3	6	12
120	36650	8.1194	1	2	5	10	18
121	163449	6.4387	2	3	5	8	12
122	80682	3.8317	1	2	3	5	7
123	40869	4.5742	1	1	3	6	11
124	134743	4.3708	1	2	3	6	8
125	74923	2.7862	1	1	2	4	5
126	5131	11.6936	3	6	9	14	22
127	680654	5.3354	2	3	4	7	10
128	11526	5.8044	3	4	5	7	9
129	4173	2.8447	1	1	1	3	7
130	89048	5.8037	2	3	5	7	10
131	26830	4.3785	1	3	4	6	7
132	152932	3.0474	1	1	2	4	6
133	7573	2.3956	1	1	2	3	4
134	32813	3.2987	1	2	3	4	6
135	7100	4.4668	1	2	3	5	9
136	1170	2.9120	1	1	2	4	6
138	191436	4.0071	1	2	3	5	8
139	77194	2.5069	1	1	2	3	5
140	76478	2.7136	1	1	2	3	5
141	85791	3.7068	1	2	3	5	7
142	42652	2.6766	1	1	2	3	5
143	185700	2.1667	1	1	2	3	4
144	78800	5.3171	1	2	4	7	11
145	6884	2.8117	1	1	2	4	6
146	11215	10.1815	5	7	9	12	17
147	2418	6.6208	3	5	6	8	10
148	134272	12.1101	5	7	10	14	22

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR Update 12/99 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
149	17551	6.6488	4	5	6	8	10
150	20300	11.1450	4	7	9	14	20
151	4479	5.9272	2	3	5	8	10
152	4441	8.1743	3	5	7	10	14
153	1914	5.4713	3	4	5	7	8
154	29346	13.2615	4	7	10	16	25
155	6052	4.3354	1	2	3	6	8
156	2	28.0000	28	28	28	28	28
157	8196	5.4926	1	2	4	7	11
158	4393	2.6271	1	1	2	3	5
159	16421	5.0258	1	2	4	6	10
160	10974	2.7204	1	1	2	4	5
161	11483	4.1695	1	2	3	5	9
162	7018	1.9577	1	1	1	2	4
163	8	2.7500	1	1	3	3	3
164	4720	8.4019	4	5	7	10	15
165	1942	4.8553	2	3	5	6	8
166	3307	5.0889	2	3	4	6	9
167	2896	2.7099	1	2	2	3	5
168	1511	4.5963	1	2	3	6	9
169	802	2.4214	1	1	2	3	5
170	11287	11.1669	2	5	8	14	23
171	1125	4.7911	1	2	4	6	9
172	30485	6.9710	2	3	5	9	14
173	2492	3.8435	1	1	3	5	8
174	236408	4.8222	2	3	4	6	9
175	28026	2.9414	1	2	3	4	5
176	15607	5.2668	2	3	4	6	10
177	9489	4.5521	2	2	4	6	8
178	3568	3.1373	1	2	3	4	6
179	12177	6.0139	2	3	5	7	11
180	85083	5.3978	2	3	4	7	10
181	24320	3.4134	1	2	3	4	6
182	232501	4.3626	1	2	3	5	8
183	78432	2.9618	1	1	2	4	6
184	98	3.2449	1	2	2	4	5
185	4300	4.4963	1	2	3	6	9
186	2	4.5000	2	2	7	7	7
187	722	3.8130	1	2	3	5	8
188	74594	5.5723	1	2	4	7	11
189	11097	3.1388	1	1	2	4	6
190	69	6.0290	2	3	4	6	11
191	9367	14.0878	4	7	10	18	28
192	974	6.5842	2	4	6	8	11
193	5669	12.5490	5	7	10	15	23
194	755	6.7497	2	4	6	8	12
195	4869	9.9029	4	6	8	12	17
196	1190	5.6832	2	4	5	7	9
197	20225	8.7363	3	5	7	11	16
198	6079	4.4996	2	3	4	6	8
199	1724	9.6456	3	4	8	12	19
200	1071	10.7404	2	4	8	14	22
201	1465	13.8314	3	6	11	18	27
202	25595	6.5031	2	3	5	8	13
203	28958	6.6940	2	3	5	9	13
204	54818	5.8581	2	3	4	7	11
205	22519	6.2964	2	3	5	8	12
206	1778	3.8335	1	2	3	5	7
207	30768	5.1176	1	2	4	6	10
208	9616	2.8974	1	1	2	4	6
209	394168	5.1231	3	3	4	6	8
210	146423	6.8039	3	4	6	8	11
211	35938	4.9292	3	4	4	6	7
212	7	3.0000	2	2	2	3	4
213	8882	8.7299	2	4	7	11	17
216	5822	9.7583	2	4	7	12	19
217	17573	13.0833	3	5	9	16	28
218	21344	5.3594	2	3	4	6	10
219	19125	3.2444	1	2	3	4	5
220	2	2.5000	1	1	4	4	4

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR Update 12/99 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
223	17434	2.5812	1	1	2	3	5
224	7953	2.0448	1	1	2	3	4
225	5575	4.7146	1	2	3	6	10
226	4985	6.2828	1	2	4	8	13
227	4416	2.6594	1	1	2	3	5
228	2437	3.5568	1	1	2	4	8
229	1080	2.3944	1	1	2	3	5
230	2102	5.1237	1	2	3	6	10
231	10618	4.8282	1	2	3	6	10
232	565	3.5894	1	1	2	4	9
233	4542	7.6797	2	3	5	9	16
234	2666	3.5709	1	2	3	4	7
235	5334	5.1245	1	2	4	6	10
236	43318	4.8912	2	3	4	6	9
237	1576	3.7386	1	2	3	5	7
238	7594	8.4664	3	4	6	10	16
239	51719	6.2172	2	3	5	8	12
240	11850	6.5754	2	3	5	8	13
241	2953	3.9401	1	2	3	5	7
242	2477	6.5268	2	3	5	8	12
243	84831	4.7022	1	3	4	6	9
244	11891	4.7802	1	2	4	6	9
245	4929	3.7206	1	2	3	4	7
246	1342	3.6461	1	2	3	4	7
247	15047	3.4443	1	1	3	4	7
248	9336	4.7321	1	2	4	6	9
249	10719	3.7768	1	1	3	5	8
250	3509	4.2485	1	2	3	5	8
251	2351	2.9872	1	1	3	4	5
252	1	2.0000	2	2	2	2	2
253	18878	4.6841	1	3	4	6	9
254	10341	3.2080	1	2	3	4	6
255	1	1.0000	1	1	1	1	1
256	5803	5.1260	1	2	4	6	10
257	16795	2.8263	1	2	2	3	5
258	15710	2.0006	1	1	2	2	3
259	3717	2.7896	1	1	1	3	6
260	4780	1.4749	1	1	1	2	2
261	1730	2.1624	1	1	1	2	4
262	673	3.8098	1	1	3	5	7
263	27219	11.5858	3	5	8	14	23
264	4261	6.9681	2	3	5	8	14
265	3868	6.6099	1	2	4	8	14
266	2527	3.3174	1	1	2	4	7
267	255	5.2353	1	1	3	6	12
268	896	3.6953	1	1	2	4	8
269	8856	8.2516	2	3	6	10	16
270	2734	3.2579	1	1	2	4	7
271	21090	7.1019	2	4	6	8	13
272	5465	6.3420	2	3	5	8	12
273	1341	4.2118	1	2	3	5	8
274	2368	6.9548	2	3	5	9	14
275	224	3.3125	1	1	2	4	7
276	1076	4.6515	1	2	4	6	9
277	83707	5.7178	2	3	5	7	10
278	28524	4.3359	2	3	4	5	7
279	4	4.0000	2	2	4	5	5
280	15047	4.1980	1	2	3	5	8
281	6682	3.0805	1	1	3	4	6
283	5322	4.5569	1	2	3	6	9
284	1852	3.1960	1	1	2	4	6
285	6125	10.4263	3	5	8	13	20
286	1995	6.2000	2	3	5	7	11
287	5974	10.5387	3	5	8	13	20
288	2252	5.7234	2	3	4	6	9
289	4326	3.1248	1	1	2	3	7
290	8214	2.4329	1	1	2	2	4
291	57	1.6316	1	1	1	2	2
292	4945	9.9610	2	4	7	13	21
293	321	4.9346	1	2	4	7	10

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR Update 12/99 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
294	83924	4.7128	1	2	4	6	9
295	3464	3.8467	1	2	3	5	7
296	232274	5.2398	2	3	4	6	10
297	40842	3.4744	1	2	3	4	6
298	106	3.1887	1	2	2	4	6
299	1052	5.5542	1	2	4	6	11
300	15582	6.1317	2	3	5	8	12
301	3101	3.7004	1	2	3	5	7
302	7525	9.4141	4	5	7	11	16
303	19405	8.4850	4	5	7	10	15
304	11967	8.8979	2	4	7	11	18
305	2852	3.8443	1	2	3	5	7
306	7925	5.4829	1	2	3	7	12
307	2226	2.2668	1	1	2	3	4
308	7673	6.3836	1	2	4	8	14
309	3947	2.4880	1	1	2	3	5
310	23701	4.3591	1	2	3	5	9
311	8200	1.8902	1	1	1	2	3
312	1570	4.5166	1	1	3	6	10
313	633	2.1153	1	1	1	3	4
314	2	1.0000	1	1	1	1	1
315	28524	7.4721	1	1	5	10	17
316	96405	6.6791	2	3	5	8	13
317	1230	3.2114	1	1	2	3	6
318	5544	5.9975	1	3	4	7	12
319	460	2.8630	1	1	2	4	6
320	181708	5.3834	2	3	4	7	10
321	28174	3.8452	1	2	3	5	7
322	69	4.0580	1	2	3	5	7
323	16353	3.2183	1	1	2	4	7
324	7365	1.8789	1	1	1	2	3
325	7788	3.8947	1	2	3	5	7
326	2414	2.6582	1	1	2	3	5
327	7	9.2857	1	1	2	4	13
328	718	3.9053	1	1	3	5	8
329	104	2.0481	1	1	1	3	4
331	43233	5.5300	1	2	4	7	11
332	4795	3.2715	1	1	2	4	7
333	296	5.0507	1	2	3	6	10
334	12132	4.8938	2	3	4	6	8
335	11393	3.4104	2	3	3	4	5
336	40525	3.5229	1	2	3	4	7
337	30540	2.1759	1	1	2	3	3
338	1641	5.2956	1	2	3	7	12
339	1503	4.5269	1	1	3	6	10
340	1	1.0000	1	1	1	1	1
341	3836	3.2018	1	1	2	3	7
342	775	3.1174	1	2	2	4	6
344	3934	2.2567	1	1	1	2	4
345	1272	3.7673	1	1	2	5	8
346	4622	5.8090	1	3	4	7	11
347	396	3.3712	1	1	2	4	7
348	3105	4.2029	1	2	3	5	8
349	589	2.6027	1	1	2	3	5
350	6157	4.3937	2	2	4	5	8
352	646	3.8498	1	2	3	5	8
353	2631	6.7081	3	3	5	8	13
354	8209	5.8725	3	3	4	7	10
355	5698	3.3243	2	3	3	4	5
356	25961	2.4179	1	1	2	3	4
357	5767	8.4947	3	4	7	10	16
358	21628	4.3926	2	3	3	5	7
359	29103	2.8141	2	2	3	3	4
360	16133	2.9634	1	2	2	3	5
361	420	3.4524	1	1	2	4	7
362	1	1.0000	1	1	1	1	1
363	3079	3.4784	1	2	2	3	7
364	1611	3.5847	1	1	2	5	7
365	1917	7.3005	2	3	5	9	16
366	4226	6.7283	1	3	5	8	14

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR Update 12/99 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
367	472	3.1462	1	1	2	4	7
368	2861	6.7113	2	3	5	8	13
369	2832	3.1963	1	1	2	4	6
370	1141	5.7160	3	3	4	5	9
371	1174	3.6567	2	3	3	4	5
372	916	3.4509	2	2	2	3	5
373	3916	2.2829	1	2	2	2	3
374	125	3.4880	2	2	2	3	5
375	6	2.6667	2	2	2	3	3
376	254	3.4803	1	2	2	4	7
377	53	3.8679	1	1	2	5	8
378	151	2.3444	1	1	2	3	4
379	355	3.1127	1	1	2	3	7
380	74	2.1622	1	1	2	2	4
381	176	1.9545	1	1	1	2	3
382	39	1.3077	1	1	1	1	2
383	1545	3.8913	1	1	3	5	8
384	123	2.3415	1	1	1	2	4
389	8	5.8750	3	3	4	8	10
390	19	3.7368	1	1	3	5	7
392	2508	9.4769	3	4	7	12	19
393	1	8.0000	8	8	8	8	8
394	1724	6.6810	1	2	4	8	15
395	80464	4.5303	1	2	3	6	9
396	17	3.7059	1	1	2	5	6
397	18071	5.2277	1	2	4	7	10
398	18051	5.9638	2	3	5	7	11
399	1614	3.5520	1	2	3	4	7
400	6845	9.0488	1	3	6	12	20
401	5827	11.1903	2	5	8	14	23
402	1483	3.9400	1	1	3	5	8
403	32911	8.0630	2	3	6	10	17
404	4457	4.2257	1	2	3	6	9
406	2546	10.2859	3	4	7	13	21
407	695	4.4086	1	2	4	6	8
408	2247	7.7036	1	2	5	10	18
409	3281	5.9113	2	3	4	6	11
410	40862	3.7202	1	2	3	5	6
411	13	2.3077	1	1	2	4	4
412	29	2.7241	1	1	2	3	6
413	6515	7.2391	2	3	6	9	14
414	746	4.0804	1	2	3	5	8
415	39856	14.1713	4	6	11	18	28
416	195783	7.3483	2	4	6	9	14
417	32	6.1875	1	2	4	7	13
418	22097	6.1239	2	3	5	7	11
419	15859	4.8212	2	2	4	6	9
420	3091	3.5642	1	2	3	4	6
421	12242	3.8638	1	2	3	5	7
422	96	5.2708	1	2	2	5	7
423	8073	8.1416	2	3	6	10	17
424	1354	13.3936	2	5	9	16	28
425	15006	4.0716	1	2	3	5	8
426	4313	4.5613	1	2	3	6	9
427	1660	5.0283	1	2	3	6	10
428	839	7.1025	1	2	4	8	15
429	30016	6.4824	2	3	5	8	12
430	58011	8.2066	2	3	6	10	16
431	295	6.5864	2	3	5	8	13
432	389	4.7506	1	2	3	5	9
433	5781	3.0073	1	1	2	4	6
434	21835	5.0844	1	2	4	6	9
435	14486	4.2925	1	2	4	5	8
436	3499	12.8337	4	7	11	17	25
437	9750	8.9544	3	5	8	11	15
439	1287	8.1756	1	3	5	10	17
440	5017	8.8433	2	3	6	10	19
441	579	3.2383	1	1	2	4	7
442	15896	8.2292	1	3	6	10	17
443	3547	3.3941	1	1	2	4	7

TABLE 7B.—MEDICARE PROSPECTIVE PAYMENT SYSTEM, SELECTED PERCENTILE LENGTHS OF STAY—Continued

[FY99 MEDPAR Update 12/99 Grouper V18.0]

DRG	Number discharges	Arithmetic mean LOS	10th percentile	25th percentile	50th percentile	75th percentile	90th percentile
444	5150	4.2252	1	2	3	5	8
445	2223	3.0031	1	1	2	4	5
447	4854	2.5117	1	1	2	3	5
448	1	4.0000	4	4	4	4	4
449	26543	3.6722	1	1	3	4	7
450	6363	2.0525	1	1	1	2	4
451	1	1.0000	1	1	1	1	1
452	21656	4.9536	1	2	3	6	10
453	4464	2.8156	1	1	2	3	5
454	4930	4.5554	1	2	3	6	9
455	1070	2.6262	1	1	2	3	5
461	3357	4.5594	1	1	2	5	11
462	12630	11.5264	4	6	9	15	21
463	18895	4.2653	1	2	3	5	8
464	5455	3.0761	1	1	2	4	6
465	227	3.3612	1	1	2	3	7
466	1719	3.8674	1	1	2	4	8
467	1301	4.0638	1	1	2	4	7
468	58391	12.9318	3	6	10	17	26
471	11423	5.7339	3	4	5	6	9
473	7615	12.8411	2	3	7	19	32
475	109112	11.1767	2	5	9	15	22
476	4448	11.6369	2	5	10	15	21
477	25690	8.1425	1	3	6	10	17
478	111191	7.3157	1	3	5	9	15
479	22375	3.6220	1	2	3	5	7
480	460	19.1848	7	9	14	23	38
481	229	27.1485	16	19	23	32	43
482	6119	12.7756	4	7	10	15	24
483	47190	38.8624	14	21	32	49	70
484	323	13.3065	2	5	10	18	28
485	2932	9.3905	4	5	7	11	17
486	2012	12.1511	1	5	9	16	24
487	3491	7.5408	1	3	6	10	15
488	767	16.9465	4	7	12	21	34
489	14253	8.5597	2	3	6	10	18
490	5283	5.1333	1	2	4	6	10
491	11332	3.4896	2	2	3	4	6
492	2667	16.1234	4	5	9	26	34
493	54030	5.7170	1	3	5	7	11
494	27254	2.4838	1	1	2	3	5
495	145	20.2552	6	8	12	18	33
496	1270	9.9843	4	5	7	12	18
497	22593	6.2173	2	3	5	7	11
498	19133	3.4179	1	2	3	4	6
499	30738	4.7687	1	2	4	6	9
500	42090	2.6897	1	1	2	3	5
501	1943	10.5713	4	5	8	13	20
502	612	5.9379	2	3	5	7	10
503	5563	3.9730	1	2	3	5	7
504	122	30.0984	10	15	25	40	60
505	153	4.7190	1	1	2	6	12
506	962	17.6258	4	8	14	24	37
507	280	9.1857	2	4	7	13	18
508	637	7.1350	2	3	5	9	15
509	165	6.1333	1	2	4	8	12
510	1653	7.8506	2	3	5	9	17
511	594	4.4646	1	1	3	6	10
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TABLE 8A.—STATEWIDE AVERAGE OPERATING COST-TO-CHARGE RATIOS FOR URBAN AND RURAL HOSPITALS (CASE WEIGHTED) MARCH 2000

State	Urban	Rural
ALABAMA	0.401	0.355
ALASKA	0.469	0.722
ARIZONA	0.373	0.516
ARKANSAS	0.478	0.454
CALIFORNIA	0.344	0.443
COLORADO	0.427	0.560
CONNECTICUT	0.495	0.503
DELAWARE	0.507	0.449
DISTRICT OF COLUMBIA	0.521	.....
FLORIDA	0.363	0.380
GEORGIA	0.474	0.486
HAWAII	0.409	0.554
IDAHO	0.549	0.570
ILLINOIS	0.427	0.515
INDIANA	0.532	0.543
IOWA	0.493	0.623
KANSAS	0.443	0.656
KENTUCKY	0.477	0.493
LOUISIANA	0.406	0.495
MAINE	0.597	0.554
MARYLAND	0.759	0.821
MASSACHUSETTS	0.525	0.537
MICHIGAN	0.558	0.597
MINNESOTA	0.510	0.590
MISSISSIPPI	0.455	0.455
MISSOURI	0.413	0.506
MONTANA	0.525	0.570
NEBRASKA	0.468	0.623
NEVADA	0.293	0.483
NEW HAMPSHIRE	0.543	0.583
NEW JERSEY	0.411	.....
NEW MEXICO	0.477	0.498
NEW YORK	0.529	0.610
NORTH CAROLINA	0.539	0.489
NORTH DAKOTA	0.622	0.660
OHIO	0.513	0.578
OKLAHOMA	0.422	0.509
OREGON	0.560	0.581
PENNSYLVANIA	0.396	0.517
PUERTO RICO	0.479	0.578
RHODE ISLAND	0.523	.....
SOUTH CAROLINA	0.456	0.452
SOUTH DAKOTA	0.537	0.600
TENNESSEE	0.441	0.482
TEXAS	0.406	0.511
UTAH	0.505	0.627
VERMONT	0.623	0.590
VIRGINA	0.467	0.500
WASHINGTON	0.577	0.652
WEST VIRGINIA	0.577	0.530
WISCONSIN	0.559	0.622
WYOMING	0.475	0.681

TABLE 8B.—STATEWIDE AVERAGE CAPITAL COST-TO-CHARGE RATIOS (CASE WEIGHTED) MARCH 2000

State	Ratio
ALABAMA	0.040
ALASKA	0.070
ARIZONA	0.041
ARKANSAS	0.050
CALIFORNIA	0.037
COLORADO	0.046
CONNECTICUT	0.036
DELAWARE	0.051
DISTRICT OF COLUMBIA	0.039
FLORIDA	0.045
GEORGIA	0.056
HAWAII	0.042
IDAHO	0.049
ILLINOIS	0.042
INDIANA	0.057
IOWA	0.056
KANSAS	0.054
KENTUCKY	0.046
LOUISIANA	0.050
MAINE	0.039
MARYLAND	0.013
MASSACHUSETTS	0.054
MICHIGAN	0.053
MINNESOTA	0.049
MISSISSIPPI	0.045
MISSOURI	0.046
MONTANA	0.050
NEBRASKA	0.054
NEVADA	0.030
NEW HAMPSHIRE	0.063
NEW JERSEY	0.037
NEW MEXICO	0.044
NEW YORK	0.051
NORTH CAROLINA	0.050
NORTH DAKOTA	0.074
OHIO	0.050
OKLAHOMA	0.048
OREGON	0.048
PENNSYLVANIA	0.040
PUERTO RICO	0.043
RHODE ISLAND	0.030
SOUTH CAROLINA	0.047
SOUTH DAKOTA	0.066
TENNESSEE	0.051
TEXAS	0.048
UTAH	0.049
VERMONT	0.051
VIRGINIA	0.058
WASHINGTON	0.064
WEST VIRGINIA	0.047
WISCONSIN	0.054
WYOMING	0.057

Appendix A—Regulatory Impact Analysis

I. Introduction

We generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless we certify that a proposed rule would not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we consider all hospitals to be small entities.

Also, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the hospital inpatient prospective payment system, we classify these hospitals as urban hospitals.

It is clear that the changes being proposed in this document would affect both a substantial number of small rural hospitals as well as other classes of hospitals, and the effects on some may be significant. Therefore, the discussion below, in combination with the rest of this proposed rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis.

We have reviewed this proposed rule under the threshold criteria of Executive Order 13132, Federalism, and have determined that the proposed rule will not have any negative impact on the rights, roles, and responsibilities of State, local, or tribal governments.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million. This proposed rule does not mandate any requirements for State, local, or tribal governments.

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

II. Objectives

The primary objective of the hospital inpatient prospective payment system is to create incentives for hospitals to operate efficiently and minimize unnecessary costs while at the same time ensuring that payments are sufficient to adequately compensate hospitals for their legitimate costs. In addition, we share national goals of preserving the Medicare Trust Fund.

We believe the proposed changes would further each of these goals while maintaining the financial viability of the hospital industry and ensuring access to high quality health care for Medicare beneficiaries. We expect that these proposed changes would ensure that the outcomes of this payment system are reasonable and equitable while avoiding or minimizing unintended adverse consequences.

III. Limitations of Our Analysis

As has been the case in our previously published regulatory impact analyses, the following quantitative analysis presents the projected effects of our proposed policy changes, as well as statutory changes effective for FY 2001, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per case while holding all other payment policies constant. We use the best data available, but we do not attempt to predict behavioral responses to our policy changes, and we do

not make adjustments for future changes in such variables as admissions, lengths of stay, or case-mix. As we have done in previous proposed rules, we are soliciting comments and information about the anticipated effects of these changes on hospitals and our methodology for estimating them.

IV. Hospitals Included In and Excluded From the Prospective Payment System

The prospective payment systems for hospital inpatient operating and capital-related costs encompass nearly all general, short-term, acute care hospitals that participate in the Medicare program. There were 44 Indian Health Service hospitals in our database, which we excluded from the analysis due to the special characteristics of the prospective payment method for these hospitals. Among other short-term, acute care hospitals, only the 50 such hospitals in Maryland remain excluded from the prospective payment system under the waiver at section 1814(b)(3) of the Act. Thus, as of February 2000, we have included 4,836 hospitals in our analysis. This represents about 80 percent of all Medicare-participating hospitals. The majority of this impact analysis focuses on this set of hospitals.

The remaining 20 percent are specialty hospitals that are excluded from the prospective payment system and continue to be paid on the basis of their reasonable costs (subject to a rate-of-increase ceiling on their inpatient operating costs per discharge). These hospitals include psychiatric, rehabilitation, long-term care, children's, and cancer hospitals. The impacts of our final policy changes on these hospitals are discussed below.

V. Impact on Excluded Hospitals and Units

As of February 2000, there were 1,081 specialty hospitals excluded from the prospective payment system and instead paid on a reasonable cost basis subject to the rate-of-increase ceiling under § 413.40. Broken down by specialty, there were 549 psychiatric, 194 rehabilitation, 238 long-term care, 73 childrens', 17 Christian Science Sanatoria, and 10 cancer hospitals. In addition, there were 1,470 psychiatric units and 910 rehabilitation units in hospitals otherwise subject to the prospective payment system. These excluded units are also paid in accordance with § 413.40. Under § 413.40(a)(2)(i)(A), the rate-of-increase ceiling is not applicable to the 36 specialty hospitals and units in Maryland that are paid in accordance with the waiver at section 1814(b)(3) of the Act.

As required by section 1886(b)(3)(B) of the Act, the update factor applicable to the rate-of-increase limit for excluded hospitals and units for FY 2001 would be between 0 and 3.1 percent, depending on the hospital's or unit's costs in relation to its limit for the most recent cost reporting period for which information is available.

The impact on excluded hospitals and units of the update in the rate-of-increase limit depends on the cumulative cost increases experienced by each excluded hospital or unit since its applicable base period. For excluded hospitals and units that have maintained their cost increases at a level below the percentage increases in the rate-of-increase limits since their base period, the major effect will be on the level of incentive payments these hospitals and units receive. Conversely, for excluded hospitals and units with per-case cost increases above the cumulative update in their rate-of-increase limits, the major effect will be the amount of excess costs that would not be reimbursed.

We note that, under § 413.40(d)(3), an excluded hospital or unit whose costs exceed 110 percent of its rate-of-increase limit receives its rate-of-increase limit plus 50 percent of the difference between its reasonable costs and 110 percent of the limit, not to exceed 110 percent of its limit. In addition, under the various provisions set forth in § 413.40, certain excluded hospitals and units can obtain payment adjustments for justifiable increases in operating costs that exceed the limit. At the same time, however, by generally limiting payment increases, we continue to provide an incentive for excluded hospitals and units to restrain the growth in their spending for patient services.

VI. Graduate Medical Education Impact of National Average Per Resident Amount (PRA)

As discussed in section IV.G. of the preamble, this proposed rule would implement statutory provisions enacted by section 311 of Public Law 106–113 that establish a methodology for the use of a national average PRA in computing direct graduate medical education (GME) payments for cost reporting periods beginning on or after October 1, 2000 and on or before September 30, 2005. The methodology would establish a ''floor'' and ''ceiling'' based on a locality-adjusted, updated national average PRA. Under section 1886(h)(2)(D)(iii) of the Act, as added by section 311(a) of Public Law 106–113, the PRA for a hospital for the cost reporting period beginning during FY 2001 cannot be below 70 percent of the locality-adjusted, updated national average PRA. Thus, if a hospital's PRA for the cost reporting period beginning during FY 2001 would otherwise be below the floor, the hospital's PRA for that cost reporting period would be equal to 70 percent of the locality-adjusted, national average PRA. Under section 1886(h)(2)(D)(iv) of the Act, as added by section 311(a) of Public Law 106–113, if a hospital's PRA exceeds 140 percent of the locality-adjusted, updated national average PRA, the hospital's PRA would be frozen (for FYs 2001 and 2002) or subject to a 2-percent reduction to the otherwise applicable update (for FYs 2003 through 2005). See section IV.G. of the preamble for a fuller explanation of this policy.

For purposes of the proposed rule, we have calculated an estimated impact of this proposed policy on teaching hospitals' PRAs for FY 2001 making assumptions about update factors and geographic adjustment factors (GAF) for each hospital. Generally, utilizing FY 1997 data, we calculated a floor and a ceiling and estimated the impact on hospitals. This impact was then inflated to FY 2001 to estimate the total impact on the Medicare program for FY 2001. The estimated numbers for this impact should not be used by hospitals in calculating their own individual PRAs; hospitals must use the methodology stated in section IV.G. of this proposed rule to revise (if appropriate) their individual PRAs.

In calculating this impact, we utilized Medicare cost report data for all cost reports ending in FY 1997. We excluded hospitals that file manual cost reports because we did not have access to their Medicare utilization data. We also excluded all teaching hospitals in Maryland because these hospitals are paid under a Medicare waiver. For those hospitals that had two cost reporting periods ending in FY 1997, we used the later of the two periods. A total of 1,231 teaching hospitals were included in this analysis.

Utilizing the proposed FY 1997 weighted average PRA of $68,487, we calculated a FY 1997 70-percent floor of $47,941 and a FY 1997 140-percent ceiling of $95,882. We then estimated that, for cost reporting periods ending in FY 1997, 339 hospitals had PRAs that were below $47,941 (27.5 percent of 1,231 hospitals), and 180 hospitals had PRAs above $95,882 (14.6 percent of 1,231 hospitals). Thus, for example, to illustrate the extremes in impact for a hospital with PRAs below the floor, Hospital A had a FY 1997 primary care PRA of $22,000 and a non-primary care PRA of $20,000. When these PRAs are replaced by a single PRA of $47,941, the hospital gains over 110 percent in payments per resident. For a hospital with PRAs above the ceiling, Hospital B had a FY 1997 primary care PRA of $150,000 and a non-primary care PRA of $148,000. When these PRAs are frozen and not updated for inflation in FY 2001, the percentage loss in payments per resident that year would be equal to the CPI–U percentage that would otherwise have been used to update the PRA.

For the 339 hospitals that had PRAs below the FY 1997 $47,941 floor, we estimated that the total cost to the Medicare program for FY 2001 of applying the floor would be $33.3 million. For the 180 hospitals that had PRAs above the FY 1997 $95,882 ceiling, we estimated that the total savings to the Medicare program for FY 2001 would be $18.7 million. Subtracting the estimated savings of $18.7 million from the estimated costs of $33.3 million yields an estimated total net cost to the Medicare program for FY 2001 of $14.6 million.

VII. Quantitative Impact Analysis of the Proposed Policy Changes Under the Prospective Payment System for Operating Costs

A. Basis and Methodology of Estimates

In this proposed rule, we are announcing policy changes and payment rate updates for the prospective payment systems for operating and capital-related costs. We estimate the total impact of these changes for FY 2001 payments compared to FY 2000 payments to be approximately a $1.3 billion increase. We have prepared separate impact analyses of the proposed changes to each system. This section deals with changes to the operating prospective payment system.

The data used in developing the quantitative analyses presented below are

taken from the FY 1999 MedPAR file and the most current provider-specific file that is used for payment purposes. Although the analyses of the changes to the operating prospective payment system do not incorporate cost data, the most recently available hospital cost report data were used to categorize hospitals. Our analysis has several qualifications. First, we do not make adjustments for behavioral changes that hospitals may adopt in response to these proposed policy changes. Second, due to the interdependent nature of the prospective payment system, it is very difficult to precisely quantify the impact associated with each proposed change. Third, we draw upon various sources for the data used to categorize hospitals in the tables. In some cases, particularly the number of beds, there is a fair degree of variation in the data from different sources. We have attempted to construct these variables with the best available source overall. For individual hospitals, however, some miscategorizations are possible.

Using cases in the FY 1999 MedPAR file, we simulated payments under the operating prospective payment system given various combinations of payment parameters. Any short-term, acute care hospitals not paid under the general prospective payment systems (Indian Health Service hospitals and hospitals in Maryland) are excluded from the simulations. Payments under the capital prospective payment system, or payments for costs other than inpatient operating costs, are not analyzed here. Estimated payment impacts of proposed FY 2001 changes to the capital prospective payment system are discussed in section IX of this Appendix.

The proposed changes discussed separately below are the following:

- The effects of the annual reclassification of diagnoses and procedures and the recalibration of the diagnosis-related group (DRG) relative weights required by section 1886(d)(4)(C) of the Act.
- The effects of changes in hospitals' wage index values reflecting the wage index update (FY 1997 data).
- The effects of our proposal to remove from the wage index the costs and hours associated with teaching physicians paid under Medicare Part A, residents, and certified registered nurse anesthetists (CRNAs) during the second year of a 5-year phase-out, by calculating a wage index based on 40 percent of hospitals' average hourly wages after removing these costs and hours, and 60 percent of hospitals' average hourly wages with these costs included.
- The effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB) that will be effective in FY 2001.
- The total change in payments based on FY 2001 policies relative to payments based on FY 2000 policies.

To illustrate the impacts of the FY 2001 proposed changes, our analysis begins with a FY 2000 baseline simulation model using: The FY 2000 DRG GROUPER (version 17.0); the FY 2000 wage index; and no MGCRB reclassifications. Outlier payments are set a 5.1 percent of total DRG plus outlier payments.

Each proposed and statutory policy change is then added incrementally to this baseline model, finally arriving at an FY 2001 model incorporating all of the changes. This allows us to isolate the effects of each change.

Our final comparison illustrates the percent change in payments per case from FY 2000 to FY 2001. Five factors have significant impacts here. The first is the update to the standardized amounts. In accordance with section 1886(d)(3)(A)(iv) of the Act, we are proposing to update the large urban and the other areas average standardized amounts for FY 2001 using the most recently forecasted hospital market basket increase for FY 2001 of 3.1 percent minus 1.1 percentage points (for an update of 2.0 percent).

Under section 1886(b)(3) of the Act, as amended by section 406 of Public Law 106–113, the updates to the average standardized amounts and the hospital-specific amounts for sole community hospitals (SCHs) will be equal to the full market basket increase for FY 2001. Consequently, the update factor used for SCHs in this impact analysis is 3.1 percent. Under section 1886(b)(3)(D) of the Act, the update factor for the hospital-specific amounts for MDHs is equal to the market basket increase of 3.1 percent minus 1.1 percentage points (for an update of 2.0 percent).

A second significant factor that impacts changes in hospitals' payments per case from FY 2000 to FY 2001 is a change in MGCRB reclassification status from one year to the next. That is, hospitals reclassified in FY 2000 that are no longer reclassified in FY 2001 may have a negative payment impact going from FY 2000 to FY 2001; conversely, hospitals not reclassified in FY 2000 that are reclassified in FY 2001 may have a positive impact. In some cases, these impacts can be quite substantial, so if a relatively small number of hospitals in a particular category lose their reclassification status, the percentage change in payments for the category may be below the national mean.

A third significant factor is that we currently estimate that actual outlier payments during FY 2000 will be 6.1 percent of actual total DRG payments. When the FY 2000 final rule was published, we projected FY 2000 outlier payments would be 5.1 percent of total DRG plus outlier payments; the standardized amounts were offset correspondingly. The effects of the higher than expected outlier payments during FY 2000 (as discussed in the Addendum to this proposed rule) are reflected in the analyses below comparing our current estimates of FY 2000 payments per case to estimated FY 2001 payments per case.

Fourth, section 111 of Public Law 106–113 revised section 1886(d)(5)(B)(ii) of the Act so that the IME adjustment changes from FY 2000 to FY 2001 from approximately a 6.25-percent increase for every 100-percent increase in a hospital's resident-to-bed ratio during FY 2000 to approximately a 6.2-percent increase in FY 2001. Similarly, section 112 of Public Law 106–113 revised section 1886(d)(5)(F)(ix) of the Act so that the DSH adjustment for FY 2001 is reduced by 3-percent from what would otherwise have been paid (this is the same percentage reduction that was applied in FY 2000).

Finally, section 405 of Public Law 106–113 provided that certain SCHs may elect to receive payment on the basis of their costs per case during their cost reporting period that began during 1996. To be eligible, a SCH must have received for its cost reporting period beginning during 1999, payment on the basis of its hospital-specific rate. For FY 2001, eligible SCHs that elect rebasing receive a hospital-specific rate comprised of 75-percent of the higher of their FY 1982 or FY 1987 hospital-specific rate, and 25-percent of their FY 1996 hospital-specific rate.

Table I demonstrates the results of our analysis. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The top row of the table shows the overall impact on the 4,836 hospitals included in the analysis. This number is 86 fewer hospitals than were included in the impact analysis in the FY 2000 final rule (64 FR 41624).

The next four rows of Table I contain hospitals categorized according to their geographic location (all urban, which is further divided into large urban and other urban, or rural). There are 2,710 hospitals located in urban areas (MSAs or NECMAs) included in our analysis. Among these, there are 1,545 hospitals located in large urban areas (populations over 1 million), and 1,165 hospitals in other urban areas (populations of 1 million or fewer). In addition, there are 2,126 hospitals in rural areas. The next two groupings are by bed-size categories, shown separately for urban and rural hospitals. The final groupings by geographic location are by census divisions, also shown separately for urban and rural hospitals.

The second part of Table I shows hospital groups based on hospitals' FY 2001 payment classifications, including any reclassifications under section 1886(d)(10) of the Act. For example, the rows labeled urban, large urban, other urban, and rural show that the number of hospitals paid based on these categorizations (after consideration of geographic reclassifications) are 2,786, 1,617, 1,169, and 2,050, respectively.

The next three groupings examine the impacts of the proposed changes on hospitals grouped by whether or not they have residency programs (teaching hospitals that receive an IME adjustment) or receive DSH payments, or some combination of these two adjustments. There are 3,730 nonteaching hospitals in our analysis, 870 teaching hospitals with fewer than 100 residents, and 236 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status, and whether they are considered urban or rural after MGCRB reclassifications. Hospitals in the rural DSH categories, therefore, represent hospitals that were not reclassified for purposes of the standardized amount or for purposes of the DSH adjustment. (They may, however, have been reclassified for purposes of the wage index.) The next category groups hospitals considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither.

The next five rows examine the impacts of the proposed changes on rural hospitals by special payment groups (SCHs, rural referral centers (RRCs), and MDHs), as well as rural hospitals not receiving a special payment designation. The RRCs (150), SCHs (660), MDHs (352), and SCH and RRCs (58) shown here were not reclassified for purposes of the standardized amount. There are 20 RRCs, 1 MDH, 5 SCHs and 2 SCH and RRCs that will be reclassified as urban for the standardized amount in FY 2001 and, therefore, are not included in these rows.

The next two groupings are based on type of ownership and the hospital's Medicare utilization expressed as a percent of total patient days. These data are taken primarily from the FY 1998 Medicare cost report files, if available (otherwise FY 1997 data are used). Data needed to determine ownership status or Medicare utilization percentages were unavailable for 34 and 35 hospitals, respectively. For the most part, these are new hospitals.

The next series of groupings concern the geographic reclassification status of hospitals. The first three groupings display hospitals that were reclassified by the MGCRB for both FY 2000 and FY 2001, or for only one of those 2 years, by urban and rural status. The next rows illustrate the overall number of FY 2001 reclassifications, as well as the numbers of reclassified hospitals grouped by urban and rural location. The final row in Table I contains hospitals located in rural counties but deemed to be urban under section 1886(d)(8)(B) of the Act.

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TABLE I - IMPACT ANALYSIS OF CHANGES FOR FY 2001
OPERATING PROSPECTIVE PAYMENT SYSTEM
(PERCENT CHANGES IN PAYMENTS PER CASE)

	NUM. OF HOSPS.[1] (0)	DRG RE-CALIB.[2] (1)	NEW WAGE DATA[3] (2)	PHASE-OUT OF GME AND CRNA COSTS[4] (3)	DRG & WI CHANGES[5] (4)	MGCRB RECLASSI-FICATION[6] (5)	ALL FY 2001 CHANGES[7] (6)
(BY GEOGRAPHIC LOCATION)							
ALL HOSPITALS	4,836	0.0	0.3	0.0	0.0	0.0	1.2
URBAN HOSPITALS	2,710	0.0	0.1	0.0	-0.1	-0.4	0.9
LARGE URBAN	1,545	0.0	-0.3	0.1	-0.5	-0.5	0.6
OTHER URBAN	1,165	0.0	0.6	0.0	0.4	-0.3	1.4
RURAL HOSPITALS	2,126	0.1	1.4	0.1	1.3	2.4	2.8
BED SIZE (URBAN)							
0- 99 BEDS	687	0.1	0.2	0.1	0.3	-0.4	1.4
100-199 BEDS	928	0.1	0.1	0.1	0.0	-0.5	1.0
200-299 BEDS	543	0.0	0.0	0.1	-0.2	-0.4	0.8
300-499 BEDS	410	-0.1	0.1	0.1	-0.2	-0.4	0.8
500 OR MORE BEDS	142	-0.1	0.1	0.0	-0.3	-0.4	1.0
BED SIZE (RURAL)							
0- 49 BEDS	1,208	0.2	1.4	0.1	1.3	0.3	3.6
50- 99 BEDS	549	0.2	1.4	0.1	1.2	0.8	3.0
100-149 BEDS	217	0.2	1.4	0.1	1.2	3.4	2.5

	NUM. OF HOSPS.[1] (0)	DRG RE-CALIB.[2] (1)	NEW WAGE DATA[3] (2)	PHASE-OUT OF GME AND CRNA COSTS[4] (3)	DRG & WI CHANGES[5] (4)	MGCRB RECLASSI-FICATION[6] (5)	ALL FY 2001 CHANGES[7] (6)
150-199 BEDS	85	0.1	1.5	0.1	1.3	4.9	2.7
200 OR MORE BEDS	67	0.1	1.4	0.1	1.2	4.1	2.2
URBAN BY CENSUS DIVISION							
NEW ENGLAND	146	0.0	-0.2	0.1	0.3	-0.2	1.2
MIDDLE ATLANTIC	412	0.0	-0.3	-0.1	-0.7	-0.5	0.0
SOUTH ATLANTIC	400	0.0	0.2	0.1	0.1	-0.5	1.1
EAST NORTH CENTRAL	457	0.0	0.1	0.0	-0.2	-0.2	1.0
EAST SOUTH CENTRAL	156	0.0	-0.6	0.0	-0.9	-0.4	0.2
WEST NORTH CENTRAL	185	-0.1	0.6	0.0	0.2	-0.4	1.5
WEST SOUTH CENTRAL	343	0.0	0.8	0.1	0.5	-0.5	1.6
MOUNTAIN	132	-0.1	0.2	0.1	-0.2	-0.4	1.3
PACIFIC	434	0.0	0.2	0.1	0.0	-0.4	1.0
PUERTO RICO	45	0.1	-0.7	0.0	-0.8	-0.5	0.9
RURAL BY CENSUS DIVISION							
NEW ENGLAND	52	0.1	0.4	0.0	0.1	2.6	2.6
MIDDLE ATLANTIC	79	0.1	0.4	0.0	0.2	2.8	2.6
SOUTH ATLANTIC	276	0.2	1.9	0.1	1.8	2.8	3.0
EAST NORTH CENTRAL	280	0.1	1.5	0.1	1.3	2.0	3.0

	NUM. OF HOSPS.[1] (0)	DRG RE-CALIB.[2] (1)	NEW WAGE DATA[3] (2)	PHASE-OUT OF GME AND CRNA COSTS[4] (3)	DRG & WI CHANGES[5] (4)	MGCRB RECLASSI-FICATION[6] (5)	ALL FY 2001 CHANGES[7] (6)
EAST SOUTH CENTRAL	265	0.2	1.4	0.1	1.3	2.2	2.4
WEST NORTH CENTRAL	491	0.1	1.3	0.0	1.0	2.5	3.1
WEST SOUTH CENTRAL	337	0.2	1.7	0.1	1.6	2.8	2.7
MOUNTAIN	201	0.1	1.0	0.0	0.8	1.7	3.1
PACIFIC	140	0.2	1.4	0.1	1.3	1.7	2.8
PUERTO RICO	5	0.2	0.1	0.1	0.2	-0.6	0.1
(BY PAYMENT CATEGORIES)							
URBAN HOSPITALS	2,786	0.0	0.1	0.0	-0.1	-0.3	0.9
LARGE URBAN	1,617	0.0	-0.3	0.1	-0.5	-0.4	0.6
OTHER URBAN	1,169	0.0	0.6	0.0	0.5	-0.3	1.4
RURAL HOSPITALS	2,050	0.2	1.4	0.1	1.3	2.1	2.8
TEACHING STATUS							
NON-TEACHING	3,730	0.1	0.5	0.1	0.4	0.3	1.4
LESS THAN 100 RESIDENTS	870	0.0	0.2	0.0	0.0	-0.2	1.1
100+ RESIDENTS	236	-0.1	-0.2	0.0	-0.5	-0.4	0.8
DISPROPORTIONATE SHARE HOSPITALS (DSH)							
NON-DSH	3,025	0.0	0.2	0.0	0.1	0.3	1.1

	NUM. OF HOSPS.[1] (0)	DRG RE-CALIB.[2] (1)	NEW WAGE DATA[3] (2)	PHASE-OUT OF GME AND CRNA COSTS[4] (3)	DRG & WI CHANGES[5] (4)	MGCRB RECLASSI-FICATION[6] (5)	ALL FY 2001 CHANGES[7] (6)
URBAN DSH							
100 BEDS OR MORE	1,377	0.0	0.2	0.0	-0.1	-0.4	1.1
FEWER THAN 100 BEDS	76	0.1	0.5	0.1	0.4	-0.5	1.6
RURAL DSH							
SOLE COMMUNITY (SCH)	153	0.2	1.6	0.1	1.5	0.6	4.7
REFERRAL CENTERS (RRC)	54	0.2	1.8	0.1	1.7	3.9	1.5
OTHER RURAL DSH HOSPITALS							
100 BEDS OR MORE	48	0.2	2.0	0.1	1.9	1.8	2.6
FEWER THAN 100 BEDS	103	0.2	2.0	0.1	2.0	0.4	3.7
URBAN TEACHING AND DSH							
BOTH TEACHING AND DSH	716	-0.1	0.1	0.0	-0.2	-0.4	1.1
TEACHING AND NO DSH	325	-0.1	-0.1	0.0	-0.4	-0.3	0.6
NO TEACHING AND DSH	737	0.1	0.3	0.1	0.2	-0.2	1.1
NO TEACHING AND NO DSH	1,008	0.1	-0.1	0.1	-0.1	-0.3	0.6
RURAL HOSPITAL TYPES							
NONSPECIAL STATUS HOSPITALS	830	0.2	1.9	0.1	1.8	1.2	3.1
RRC	150	0.1	1.7	0.1	1.6	5.3	2.1
SCH	660	0.2	0.8	0.0	0.7	0.4	3.5
MDH	352	0.2	1.4	0.1	1.3	0.3	3.1

	NUM. OF HOSPS.[1] (0)	DRG RE-CALIB.[2] (1)	NEW WAGE DATA[3] (2)	PHASE-OUT OF GME AND CRNA COSTS[4] (3)	DRG & WI CHANGES[5] (4)	MGCRB RECLASSI-FICATION[6] (5)	ALL FY 2001 CHANGES[7] (6)
SCH AND RRC	58	0.1	0.6	0.0	0.4	1.8	2.1
TYPE OF OWNERSHIP							
VOLUNTARY	2,820	0.0	0.2	0.0	0.0	-0.1	1.1
PROPRIETARY	768	0.1	0.2	0.1	0.0	0.0	0.9
GOVERNMENT	1,214	0.0	0.7	0.1	0.4	0.3	1.9
UNKNOWN	34	-0.2	-0.2	0.0	-0.7	-0.5	0.5
MEDICARE UTILIZATION AS A PERCENT OF INPATIENT DAYS							
0 - 25	379	0.0	0.2	0.1	-0.1	-0.1	1.4
25 - 50	1,830	0.0	0.1	0.1	-0.2	-0.3	1.0
50 - 65	1,893	0.0	0.5	0.0	0.3	0.2	1.3
OVER 65	699	0.1	0.3	0.0	0.3	0.3	1.2
UNKNOWN	35	-0.2	-0.2	0.0	-0.7	-0.5	0.5
HOSPITALS RECLASSIFIED BY THE MEDICARE GEOGRAPHIC REVIEW BOARD							
RECLASSIFICATION STATUS DURING FY 2000 AND FY 2001							
RECLASSIFIED DURING BOTH FY 2000 AND FY 2001	381	0.1	1.2	0.1	1.1	5.4	1.2
URBAN	52	0.0	0.8	0.1	1.0	4.8	-0.2

	NUM. OF HOSPS.[1] (0)	DRG RE-CALIB.[2] (1)	NEW WAGE DATA[3] (2)	PHASE-OUT OF GME AND CRNA COSTS[4] (3)	DRG & WI CHANGES[5] (4)	MGCRB RECLASSI-FICATION[6] (5)	ALL FY 2001 CHANGES[7] (6)
RURAL	329	0.1	1.4	0.1	1.2	5.7	1.8
RECLASSIFIED DURING FY 2001 ONLY	160	0.1	1.1	0.1	0.9	3.9	6.1
URBAN	41	0.0	0.6	0.0	0.3	3.3	4.2
RURAL	119	0.2	1.7	0.1	1.5	4.6	8.5
RECLASSIFIED DURING FY 2000 ONLY	118	0.0	0.5	0.1	0.2	-0.8	-2.8
URBAN	31	0.0	-0.2	0.1	-0.5	-1.1	-2.7
RURAL	87	0.2	1.5	0.1	1.4	-0.4	-2.9
FY 2001 RECLASSIFICATIONS							
ALL RECLASSIFIED HOSPITALS	541	0.1	1.2	0.1	1.0	5.0	2.4
STANDARDIZED AMOUNT ONLY	66	0.1	0.8	0.1	0.7	3.7	0.6
WAGE INDEX ONLY	386	0.1	1.2	0.1	1.1	4.3	0.7
BOTH	46	0.1	0.0	0.1	-0.2	4.4	-1.1
NONRECLASSIFIED	4,312	0.0	0.2	0.0	-0.1	-0.5	1.2
ALL URBAN RECLASSIFIED	93	0.0	0.7	0.1	0.7	4.2	1.5
STANDARDIZED AMOUNT ONLY	16	0.2	-0.6	0.0	-0.7	0.7	0.3
WAGE INDEX ONLY	59	0.0	0.7	0.1	0.8	4.8	2.2
BOTH	18	0.0	1.4	0.1	1.1	3.2	-0.9

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	NUM. OF HOSPS.[1] (0)	DRG RE-CALIB.[2] (1)	NEW WAGE DATA[3] (2)	PHASE-OUT OF GME AND CRNA COSTS[4] (3)	DRG & WI CHANGES[5] (4)	MGCRB RECLASSI-FICATION[6] (5)	ALL FY 2001 CHANGES[7] (6)
NONRECLASSIFIED	2,592	0.0	0.0	0.0	-0.2	-0.6	0.9
ALL RURAL RECLASSIFIED	448	0.1	1.4	0.1	1.2	5.5	2.9
STANDARDIZED AMOUNT ONLY	53	0.1	1.5	0.1	1.3	4.3	2.7
WAGE INDEX ONLY	372	0.1	1.4	0.1	1.3	5.4	2.9
BOTH	23	0.0	0.9	0.1	0.6	8.4	3.7
NONRECLASSIFIED	1,677	0.2	1.4	0.1	1.3	-0.4	2.7
OTHER RECLASSIFIED HOSPITALS (SECTION 1886(d)(8)(B))	26	0.2	-0.2	0.0	-0.3	1.4	0.9

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 1999, and hospital cost report data are from reporting periods beginning in FY 1997 and FY 1998.

[2] This column displays the payment impact of the recalibration of the DRG weights based on FY 1999 MedPAR data and the DRG reclassification changes, in accordance with section 1886(d)(4)(C) of the Act.

[3] This column shows the payment effects of updating the data used to calculate the wage index with data from the FY 1997 cost reports.

[4] This column displays the impact of removing 60 percent of the costs and hours associated with teaching physicians Part A, residents, and CRNAs from the wage index calculation.

[5] This column displays the combined impact of the reclassification and recalibration of the DRGs, the updated and revised wage data used to calculate the wage index, and the budget neutrality adjustment factor for these two changes, in accordance with sections 1886(d)(4)(C)(iii) and 1886(d)(3)(E) of the Act. Thus, it represents the combined impacts shown in columns 1, 2 and 3, and the FY 2001 budget neutrality factor of .996506.

[6] Shown here are the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB). The effects demonstrate the FY 2001 payment impact of going from no reclassifications to the reclassifications scheduled to be in effect for FY 2001. Reclassification for prior years has no bearing on the payment impacts shown here.

[7] This column shows changes in payments from FY 2000 to FY 2001. It incorporates all of the changes displayed in columns 4 and 5 (the changes displayed in columns 1, 2, and 3 are included in column 4). It also displays the impact of the FY 2001 update (including the higher update for SCHs), changes in hospitals' reclassification status in FY 2001 compared to FY 2000, the difference in outlier payments from FY 2000 to FY 2001, and the reductions to payments through the IME adjustment taking effect during FY 2001. It also reflects section 405 of Public law 106-113, which permitted certain SCHs to rebase for a 1996 hospital-specific rate. The sum of these columns may be different from the percentage changes shown here due to rounding and interactive effects.

B. Impact of the Proposed Changes to the DRG Reclassifications and Recalibration of Relative Weights (Column 1)

In column 1 of Table I, we present the combined effects of the DRG reclassifications and recalibration, as discussed in section II of the preamble to this proposed rule. Section 1886(d)(4)(C)(i) of the Act requires us to annually make appropriate classification changes and to recalibrate the DRG weights in order to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources.

We compared aggregate payments using the FY 2000 DRG relative weights (GROUPER version 17) to aggregate payments using the proposed FY 2001 DRG relative weights (GROUPER version 18). Overall payments are unaffected by the DRG reclassification and recalibration. Consistent with the minor changes we are proposing for the FY 2001 GROUPER, the redistributional impacts of DRG reclassifications and recalibration across hospital groups are very small (a 0.0 percent impact for large and other urban hospitals; a 0.1 percent increase for rural hospitals). Within hospital categories, the net effects for urban hospitals are small positive changes for small hospitals (a 0.1 percent increase for hospitals with fewer than 200 beds), and small decreases for larger hospitals (a 0.1 percent decrease for hospitals with more than 300 beds). Among rural hospitals, small hospital categories experience the largest increases, a 0.2 percent increase for hospitals with fewer than 50 beds.

The breakdown by urban census division shows that the small decrease among urban hospitals is confined to the West North Central and Mountain regions. Payments to urban hospitals in most other regions are unchanged, while payments to urban hospitals in Puerto Rico rise by 0.1 percent. All rural hospital census divisions experience payment increases ranging from 0.1 percent for hospitals in New England, Middle Atlantic, East North Central, West North Central, and Mountain regions to 0.2 percent for hospitals in the South Atlantic, East South Central, West South Central, Pacific, and Puerto Rico census divisions.

C. Impact of Updating the Wage Data (Column 2)

Section 1886(d)(3)(E) of the Act requires that, beginning October 1, 1993, we annually update the wage data used to calculate the wage index. In accordance with this requirement, the proposed wage index for FY 2001 is based on data submitted for hospital cost reporting periods beginning on or after October 1, 1996 and before October 1, 1997. As with the previous column, the impact of the new data on hospital payments is isolated by holding the other payment parameters constant in the two simulations. That is, column 2 shows the percentage changes in payments when going from a model using the FY 2000 wage index (based on FY 1996 wage data before geographic reclassifications to a model using the FY 2001 prereclassification wage index based on FY 1997 wage data). Sections 152 and 154 of Public Law 106–113 reclassified certain hospitals for purposes of the wage index standardized amounts. For purposes of this column, these hospitals are located in their prereclassification geographic location. The impacts of these statutory reclassifications are shown in column 5, when examining the impacts of geographic reclassification.

The wage data collected on the FY 1997 cost reports are similar to the data used in the calculation of the FY 2000 wage index. For a thorough discussion of the data used to calculate the wage index, see section III.B. of this proposed rule.

The results indicate that the new wage data have an overall impact of a 0.3 percent increase in hospital payments (prior to applying the budget neutrality factor, see column 5). Rural hospitals especially appear to benefit from the update. Their payments increase by 1.4 percent. These increases are attributable to relatively large increases in the wage index values for the rural areas of particular States; Hawaii, Louisiana, and Montana all had increases greater than 6 percent in their prereclassification wage index values.

Urban hospitals as a group are not significantly affected by the updated wage data. The gains of hospitals in other urban areas (0.6 percent increase) are offset by decreases among hospitals in large urban areas (0.3 percent decrease). Urban hospitals in Puerto Rico experience a 7.0 percent decrease, largely due to declines of 6 percent or more in the prereclassified FY 2001 wage indexes of 2 MSAs. Urban hospitals in the East South Central census region experience a 6 percent decline due to several MSAs in Tennessee with prereclassified FY 2001 wage indexes that fall by 6 percent or more. We note that the wage data used for the proposed wage index are based upon the data available as of February 22, 2000 and, therefore, do not reflect revision requests received and processed by the fiscal intermediaries after that date. To the extent these requests are granted by hospitals' fiscal intermediaries, these revisions will be reflected in the final rule. In addition, we continue to verify the accuracy of the data for hospitals with extraordinary changes in their data from the prior year.

The largest increases are seen in the rural census divisions. Rural South Atlantic experiences the greatest positive impact, 1.9 percent. Hospitals in five other census divisions receive positive impacts over 1.0 percent: West South Central at 1.7, East North Central at 1.5, East South Central at 1.4, Pacific at 1.4, and West North Central at 1.3. The following chart compares the shifts in wage index values for labor market areas for FY 2000 relative to FY 2001. This chart demonstrates the impact of the proposed changes for the FY 2001 wage index relative to the FY 2000 wage index. The majority of labor market areas (322) experience less than a 5-percent change. A total of 39 labor market areas experience an increase of more than 5 percent with 12 having an increase greater than 10 percent. A total of 15 areas experience decreases of more than 5-percent. Of those, 10 decline by 10 percent or more.

Percentage change in area wage index values	Number of labor market areas	
	FY 2000	FY 2001
Increase more than 10 percent	8	12
Increase more than 5 percent and less than 10 percent	22	27
Increase or decrease less than 5 percent	318	322
Decrease more than 5 percent and less than 10 percent	17	5
Decrease more than 10 percent	5	10

Among urban hospitals, 125 would experience an increase of between 5 and 10 percent and 19 more than 10 percent. A total of 401 rural hospitals have increases greater than 5 percent, but none greater than 10 percent. On the negative side, 55 urban hospitals have decreases in their wage index values of at least 5 percent but less than 10 percent. Twelve urban hospitals have decreases in their wage index values greater than 10 percent. There are no rural hospitals with decreases in their wage index values greater than 5 percent or with increases of more than 10 percent. The following chart shows the projected impact for urban and rural hospitals.

Percentage change in area wage index values	Number of hospitals	
	Urban	Rural
Increase more than 10 percent	19	0
Increase more than 5 percent and less than 10 percent	125	401
Increase or decrease less than 5 percent	2,499	1,725

Percentage change in area wage index values	Number of hospitals	
	Urban	Rural
Decrease more than 5 percent and less than 10 percent	55	0
Decrease more than 10 percent	12	0

D. Impact of 5-Year Phase-Out of Teaching Physicians', Residents', and CRNAs' Costs (Column 3)

As described in section III.C. of this preamble, the proposed FY 2001 wage index is calculated by blending 60 percent of hospitals' average hourly wages calculated without removing teaching physician (paid under Medicare Part A), residents, or CRNA costs (and hours); and 40 percent of average hourly wages calculated after removing these costs (and hours). This constitutes the second year of a 5-year phase-out of these costs and hours, where the proportion of the calculation based upon average hourly wages after removing these costs increases by 20 percentage points per year.

In order to determine the impact of moving from the 80/20 blend percentage to the 60/40 blend percentage, we first estimated the payments for FY 2001 using the FY 2001 prereclassified wage index calculated using the 80/20 blend percentage (Column 2). We then estimated what the payments for FY 2001 would have been if the 60/40 blend percentage was applied to the FY 2001 prereclassified wage index. Column 3 compares the differences in these payment estimates and shows that the 60/40 blend percentage does not significantly impact overall payments (0.0 percent change). Only 53 labor market areas experience a decrease in their wage index and none decreases by more than −0.1 percent.

E. Combined Impact of DRG and Wage Index Changes—Including Budget Neutrality Adjustment (Column 4)

The impact of DRG reclassifications and recalibration on aggregate payments is required by section 1886(d)(4)(C)(iii) of the Act to be budget neutral. In addition, section 1886(d)(3)(E) of the Act specifies that any updates or adjustments to the wage index are to be budget neutral. As noted in the Addendum to this proposed rule, we compared simulated aggregate payments using the FY 2000 DRG relative weights and wage index to simulated aggregate payments using the proposed FY 2001 DRG relative weights and blended wage index. Based on this comparison, we computed a wage and recalibration budget neutrality factor of 0.996506. In Table I, the combined overall impacts of the effects of both the DRG reclassifications and recalibration and the updated wage index are shown in column 4. The 0.0 percent impact for all hospitals demonstrates that these changes, in combination with the budget neutrality factor, are budget neutral.

For the most part, the changes in this column are the sum of the changes in columns 1, 2, and 3, minus approximately 0.3 percent attributable to the budget neutrality factor. There may be some variation of plus or minus 0.1 percent due to rounding.

F. Impact of MGCRB Reclassifications (Column 5)

Our impact analysis to this point has assumed hospitals are paid on the basis of their actual geographic location (with the exception of ongoing policies that provide that certain hospitals receive payments on bases other than where they are geographically located, such as hospitals in rural counties that are deemed urban under section 1886(d)(8)(B) of the Act). The changes in column 5 reflect the per case payment impact of moving from this baseline to a simulation incorporating the MGCRB decisions for FY 2001. As noted below, these decisions affect hospitals' standardized amount and wage index area assignments. In addition, until FY 2002, rural hospitals reclassified for purposes of the standardized amount qualify to be treated as urban for purposes of the DSH adjustment.

Beginning in 1998, by February 28 of each year, the MGCRB makes reclassification determinations that will be effective for the next fiscal year, which begins on October 1. (In previous years, these determinations were made by March 30.) The MGCRB may approve a hospital's reclassification request for the purpose of using the other area's standardized amount, wage index value, or both, or for FYs 1999 through 2001, for purposes of qualifying for a DSH adjustment or to receive a higher DSH payment.

The proposed FY 2001 wage index values incorporate all of the MGCRB's reclassification decisions for FY 2001. The wage index values also reflect any decisions made by the HCFA Administrator through the appeals and review process for MGCRB decisions as of February 29, 2000. Additional changes that result from the Administrator's review of MGCRB decisions or a request by a hospital to withdraw its application will be reflected in the final rule for FY 2001.

Section 152 of Public Law 106–113 reclassified certain hospitals for purposes of the wage index and the standardized amounts. The impacts of these statutory reclassifications are included in this column.

The overall effect of geographic reclassification is required by section 1886(d)(8)(D) of the Act to be budget neutral. Therefore, we applied an adjustment of 0.994270 to ensure that the effects of reclassification are budget neutral. (See section II.A.4.b. of the Addendum to this proposed rule.)

As a group, rural hospitals benefit from geographic reclassification. Their payments rise 2.4 percent, while payments to urban hospitals decline 0.4 percent. Hospitals in other urban areas see a decrease in payments of 0.3 percent, while large urban hospitals lose 0.5 percent. Among urban hospital groups (that is, bed size, census division, and special payment status), payments generally decline.

A positive impact is evident among most of the rural hospital groups. The largest decrease among the rural census divisions is 0.6 percent for Puerto Rico. The largest increases are in rural Middle Atlantic and West South Central. These regions all receive an increase of 2.8 percent.

Among rural hospitals designated as RRCs, 127 hospitals are reclassified for purposes of the wage index only, leading to the 5.3 percent increase in payments among RRCs overall. This positive impact on RRCs is also reflected in the category of rural hospitals with 150–199 beds, which has a 4.9 percent increase in payments.

Rural hospitals reclassified for FY 2000 and FY 2001 experience a 5.7 percent increase in payments. This may be due to the fact that these hospitals have the most to gain from reclassification and have been reclassified for a period of years. Rural hospitals reclassified for FY 2001 only experience a 4.6 percent increase in payments, while rural hospitals reclassified for FY 2000 only experience a 0.4 percent decrease in payments. Urban hospitals reclassified for FY 2001 but not FY 2000 experience a 3.3 percent increase in payments overall. Urban hospitals reclassified for FY 2000 but not for FY 2001 experience a 1.1 percent decline in payments.

The FY 2001 Reclassification rows of Table I show the changes in payments per case for all FY 2001 reclassified and nonreclassified hospitals in urban and rural locations for each of the three reclassification categories (standardized amount only, wage index only, or both). The table illustrates that the largest impact for reclassified rural hospitals is for those hospitals reclassified for both the standardized amount and the wage index. These hospitals receive an 8.4 percent increase in payments. In addition, rural hospitals reclassified just for the wage index receive a 5.4 percent payment increase. The overall impact on reclassified hospitals is to increase their payments per case by an average of 5 percent for FY 2001.

The reclassification of hospitals primarily affects payment to nonreclassified hospitals through changes in the wage index and the geographic reclassification budget neutrality adjustment required by section 1886(d)(8)(D) of the Act. Among hospitals that are not reclassified, the overall impact of hospital reclassifications is an average decrease in payments per case of about 0.4 percent. Rural nonreclassified hospitals decrease by 0.4 percent, and urban nonreclassified hospitals lose 0.6 percent (the amount of the budget neutrality offset).

The foregoing analysis was based on MGCRB and HCFA Administrator decisions made by February 29, 2000. As previously noted, there may be changes to some MGCRB decisions through the appeals, review, and applicant withdrawal process. The outcome

of these cases will be reflected in the analysis presented in the final rule.

G. All Changes (Column 6)

Column 6 compares our estimate of payments per case, incorporating all changes reflected in this proposed rule for FY 2001 (including statutory changes), to our estimate of payments per case in FY 2000. It includes the effects of the 2.0 percent update to the standardized amounts and the hospital-specific rates for MDHs and the 3.1 percent update for SCHs. It also reflects the 1.0 percentage point difference between the projected outlier payments in FY 2000 (5.1 percent of total DRG payments) and the current estimate of the percentage of actual outlier payments in FY 2000 (6.1 percent), as described in the introduction to this Appendix and the Addendum to this proposed rule.

Another change affecting the difference between FY 2000 and FY 2001 payments arises from section 1886(d)(5)(8) of the Act, as amended by Public Law 106–113. As noted in the introduction to this impact analysis, for FY 2001, the IME adjustment is decreased from last year (6.5 percent in FY 2000 and 6.25 percent in FY 2001).

We also note that column 6 includes the impacts of FY 2001 MGCRB reclassifications compared to the payment impacts of FY 2000 reclassifications. Therefore, when comparing FY 2001 payments to FY 2000, the percent changes due to FY 2001 reclassifications shown in column 5 need to be offset by the effects of reclassification on hospitals' FY 2000 payments (column 7 of Table 1, July 30, 1999 final rule (64 FR 41625)). For example, the impact of MGCRB reclassifications on rural hospitals' FY 2001 payments was approximately a 2.4 percent increase, offsetting most of the 2.6 percent increase in column 7 for FY 2000. Therefore, the net change in FY 2001 payments due to reclassification for rural hospitals is actually a decrease of 0.2 percent relative to FY 2000. However, last year's analysis contained a somewhat different set of hospitals, so this might affect the numbers slightly.

Finally, section 405 of Public Law 106–113 provided that certain SCHs may elect to receive payment on the basis of their costs per case during their cost reporting period that began during 1996. To be eligible, a SCH must have received payment for cost reporting periods beginning during 1999 on the basis of its hospital-specific rate. For FY 2001, eligible SCHs that elect rebasing receive a hospital-specific rate comprised of 75 percent of the higher of their FY 1982 or FY 1987 hospital-specific rate, and 25 percent of their 1996 hospital-specific rate. The impact of this provision is modeled in column 6 as well.

There might also be interactive effects among the various factors comprising the payment system that we are not able to isolate. For these reasons, the values in column 6 may not equal the sum of the changes in columns 4 and 5, plus the other impacts that we are able to identify.

The overall payment change from FY 2000 to FY 2001 for all hospitals is a 1.2 percent increase. This reflects the 2.0 percent update for FY 2001 (3.1 percent for SCHs), the 1.0 percent lower outlier payments in FY 2001 compared to FY 2000 (5.1 percent compared to 6.1 percent); the change in the IME adjustment (6.5 in FY 2000 to 6.2 in FY 2001); and the rebasing of certain SCHs to their 1996 hospital-specific rate.

Hospitals in urban areas experience a 0.9 percent increase in payments per case compared to FY 2000. The 0.4 percent negative impact due to reclassification is offset by an identical negative impact for FY 2000. Hospitals in rural areas, meanwhile, experience a 2.8 percent payment increase. As discussed previously, this is primarily due to the positive effect of the wage index and DRG changes (1.2 percent increase).

Among urban census divisions, other than the Middle Atlantic and East South Central regions (which experience no change and a 0.2 percent increase in payments, respectively), payments increased between 0.9 and 1.6 percent between FY 2000 and FY 2001. The rural census division experiencing the smallest increase in payments was Puerto Rico (0.1 percent). The largest increases by rural hospitals are in the Mountain and West North Central regions, both with 3.1 percent. Among other rural census divisions, the largest increases are in the South Atlantic and the East North Central, both with 3.0.

Among special categories of rural hospitals, those hospitals receiving payment under the hospital-specific methodology (SCHs, MDHs, and SCH/RRCs) experience payment increases of 3.5 percent, 3.1 percent, and 2.1 percent, respectively. This outcome is primarily related to the fact that, for hospitals receiving payments under the hospital-specific methodology, there are no outlier payments. Therefore, these hospitals do not experience negative payment impacts from the decline in outlier payments from FY 2000 to FY 2001 (from 6.1 of total DRG plus outlier payments to 5.1 percent) as do hospitals paid based on the national standardized amounts.

The largest negative payment impacts from FY 2000 to FY 2001 are among hospitals that were reclassified for FY 2000 and are not reclassified for FY 2001. Overall, these hospitals lose 2.8 percent. The urban hospitals in this category lose 2.7 percent, while the rural hospitals lose 2.9 percent. On the other hand, hospitals reclassified for FY 2001 that were not reclassified for FY 2000 would experience the greatest payment increases: 6.1 percent overall; 8.5 percent for 119 rural hospitals in this category and 4.2 percent for 41 urban hospitals.

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2000 OPERATING PROSPECTIVE PAYMENT SYSTEM

[Payments per case]

(BY GEOGRAPHIC LOCATION)	Number of hospitals (1)	Average FY 2000 payment per case (2) [1]	Average FY 2001 payment per case (3) [1]	All changes (4)
ALL HOSPITALS	4,836	$6,816	$6,895	1.2
URBAN HOSPITALS	2,710	7,391	7,457	0.9
LARGE URBAN AREAS	1,545	7,927	7,973	0.6
OTHER URBAN AREAS	1,165	6,694	6,786	1.4
RURAL HOSPITALS	2,126	4,565	4,695	2.8
BED SIZE (URBAN):				
0–99 BEDS	687	4,970	5,041	1.4
100–199 BEDS	928	6,235	6,300	1.0
200–299 BEDS	543	7,022	7,076	0.8
300–499 BEDS	410	7,884	7,943	0.8
500 OR MORE BEDS	142	9,762	9,859	1.0
BED SIZE (RURAL):				
0–49 BEDS	1,208	3,787	3,925	3.6
50–99 BEDS	549	4,273	4,402	3.0
100–149 BEDS	217	4,671	4,789	2.5
150–199 BEDS	85	5,112	5,251	2.7
200 OR MORE BEDS	67	5,719	5,847	2.2
URBAN BY CENSUS DIVISION:				
NEW ENGLAND	146	7,843	7,939	1.2
MIDDLE ATLANTIC	412	8,311	8,314	0.0

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2000 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per case]

(BY GEOGRAPHIC LOCATION)	Number of hospitals (1)	Average FY 2000 payment per case (2)[1]	Average FY 2001 payment per case (3)[1]	All changes (4)
SOUTH ATLANTIC	400	7,045	7,120	1.1
EAST NORTH CENTRAL	457	7,113	7,187	1.0
EAST SOUTH CENTRAL	156	6,648	6,660	0.2
WEST NORTH CENTRAL	185	7,128	7,235	1.5
WEST SOUTH CENTRAL	343	6,788	6,898	1.6
MOUNTAIN	132	7,047	7,138	1.3
PACIFIC	434	8,591	8,678	1.0
PUERTO RICO	45	3,169	3,198	0.9
RURAL BY CENSUS DIVISION:				
NEW ENGLAND	52	5,462	5,604	2.6
MIDDLE ATLANTIC	79	4,927	5,056	2.6
SOUTH ATLANTIC	276	4,698	4,840	3.0
EAST NORTH CENTRAL	280	4,615	4,751	3.0
EAST SOUTH CENTRAL	265	4,231	4,331	2.4
WEST NORTH CENTRAL	491	4,380	4,517	3.1
WEST SOUTH CENTRAL	337	4,062	4,170	2.7
MOUNTAIN	201	4,895	5,046	3.1
PACIFIC	140	5,612	5,769	2.8
PUERTO RICO	5	2,455	2,457	0.1
(BY PAYMENT CATEGORIES)				
URBAN HOSPITALS:	2,786	7,352	7,419	0.9
LARGE URBAN	1,617	7,852	7,898	0.6
OTHER URBAN	1,169	6,681	6,776	1.4
RURAL HOSPITALS	2,050	4,538	4,665	2.8
TEACHING STATUS:				
NON-TEACHING	3,730	5,502	5,578	1.4
FEWER THAN 100 RESIDENTS	870	7,175	7,256	1.1
100 OR MORE RESIDENTS	236	10,914	11,001	0.8
DISPROPORTIONATE SHARE HOSPITALS (DSH):				
NON–DSH	3,025	5,850	5,915	1.1
URBAN DSH:				
100 BEDS OR MORE	1,377	7,959	8,047	1.1
FEWER THAN 100 BEDS	76	4,966	5,045	1.6
RURAL DSH:				
SOLE COMMUNITY (SCH)	153	4,198	4,397	4.7
REFERRAL CENTERS (RRC)	54	5,384	5,465	1.5
OTHER RURAL DSH HOSPITALS:				
100 BEDS OR MORE	48	4,141	4,249	2.6
FEWER THAN 100 BEDS	103	3,706	3,844	3.7
URBAN TEACHING AND DSH:				
BOTH TEACHING AND DSH	716	8,864	8,962	1.1
TEACHING AND NO DSH	325	7,372	7,413	0.6
NO TEACHING AND DSH	737	6,362	6,432	1.1
NO TEACHING AND NO DSH	1,008	5,711	5,744	0.6
RURAL HOSPITAL TYPES:				
NONSPECIAL STATUS HOSPITALS	830	3,968	4,092	3.1
RRC	150	5,269	5,380	2.1
SCH	660	4,534	4,692	3.5
MDH	352	3,786	3,903	3.1
SCH AND RRC	58	5,533	5,651	2.1
TYPE OF OWNERSHIP:				
VOLUNTARY	2,820	6,987	7,062	1.1
PROPRIETARY	768	6,276	6,335	0.9
GOVERNMENT	1,214	6,307	6,427	1.9
UNKNOWN	34	11,179	11,236	0.5
MEDICARE UTILIZATION AS A PERCENT OF INPATIENT DAYS:				
0–25	379	9,010	9,136	1.4
25–50	1,830	7,891	7,972	1.0
50–65	1,893	5,958	6,036	1.3
OVER 65	699	5,297	5,358	1.2
UNKNOWN	35	11,178	11,236	0.5
HOSPITALS RECLASSIFIED BY THE MEDICARE GEOGRAPHIC REVIEW BOARD:				
RECLASSIFICATION STATUS DURING FY 2000 AND FY 2001:				
RECLASSIFIED DURING BOTH FY 2000 AND FY 2001	381	5,848	5,921	1.2
URBAN	52	8,046	8,033	−0.2
RURAL	329	5,272	5,367	1.8

TABLE II.—IMPACT ANALYSIS OF CHANGES FOR FY 2000 OPERATING PROSPECTIVE PAYMENT SYSTEM—Continued

[Payments per case]

	Number of hospitals	Average FY 2000 payment per case	Average FY 2001 payment per case	All changes
	(1)	(2) [1]	(3) [1]	(4)
RECLASSIFIED DURING FY 2001 ONLY	160	5,900	6,259	6.1
URBAN	41	7,600	7,917	4.2
RURAL	119	4,604	4,994	8.5
RECLASSIFIED DURING FY 2000 ONLY	118	5,940	5,774	−2.8
URBAN	31	7,428	7,226	−2.7
RURAL	87	4,584	4,449	−2.9
FY 2000 RECLASSIFICATIONS:				
ALL RECLASSIFIED HOSPITALS	541	5,861	6,005	2.4
STANDARDIZED AMOUNT ONLY	66	4,864	4,892	0.6
WAGE INDEX ONLY	386	5,889	5,930	0.7
BOTH	46	6,494	6,424	−1.1
NONRECLASSIFIED	4,312	6,944	7,030	1.2
ALL URBAN RECLASSIFIED	93	7,865	7,986	1.5
STANDARDIZED AMOUNT ONLY	16	5,230	5,246	0.3
WAGE INDEX ONLY	59	8,321	8,508	2.2
BOTH	18	8,036	7,962	−0.9
NONRECLASSIFIED	2,592	7,384	7,447	0.9
ALL RURAL RECLASSIFIED	448	5,145	5,296	2.9
STANDARDIZED AMOUNT ONLY	53	4,728	4,856	2.7
WAGE INDEX ONLY	372	5,177	5,327	2.9
BOTH	23	5,267	5,460	3.7
NONRECLASSIFIED	1,677	4,121	4,234	2.7
OTHER RECLASSIFIED HOSPITALS (SECTION 1886(d)(8)(B))	26	4,765	4,808	0.9

[1] These payment amounts per case do not reflect any estimates of annual case-mix increase.

Table II presents the projected impact of the proposed changes for FY 2001 for urban and rural hospitals and for the different categories of hospitals shown in Table I. It compares the estimated payments per case for FY 2000 with the average estimated per case payments for FY 2001, as calculated under our models. Thus, this table presents, in terms of the average dollar amounts paid per discharge, the combined effects of the changes presented in Table I. The percentage changes shown in the last column of Table II equal the percentage changes in average payments from column 6 of Table I.

VIII. Impact of Organ, Tissue and Eye Procurement Condition of Participation on CAHs

In this proposed rule, we propose to add a CoP for organ, tissue and eye procurement for CAHs. We do not anticipate that this condition would have a substantial economic impact on CAHs. However, we believe it is desirable to inform the public of our projections of its likely effects. There are several provisions in this proposed condition that would impact CAHs to a greater or lesser degree. Specifically, CAHs would be required to have written protocols; have agreements with an OPO, a tissue bank, and an eye bank; refer all deaths that occur in the CAH to the OPO or a third party designated by the OPO; ensure that CAH employees who initiate a request for donation to the family of a potential donor have been trained as a designated requestor; and work cooperatively with the OPO, tissue bank, and eye bank in educating CAH staff, reviewing death records, and maintaining potential donors. It is important to note that because of the inherent flexibility of this condition, the extent of its economic impact is dependent upon decisions that will be made either by the CAH or by the CAH in conjunction with the OPO or the tissue and eye banks. Thus, the impact on individual CAHs will vary and is subject in large part to their decision making. The impact will also vary based on whether a CAH currently has an organ donation protocol and its level of compliance with existing law and regulations. For example, if a CAH was a Medicare hospital in compliance with the hospital CoP for organ, tissue, and eye procurement prior to converting to a CAH, there will be no additional impact.

The first requirement in the proposed CoP is that CAHs have and implement written protocols that reflect the various other requirements of the proposed CoP. Currently, under section 1138 of the Act, CAHs must have written protocols for organ donation. Most CAHs will need to rewrite their existing protocols to conform with this regulation; however, this is clearly not a requirement that imposes a significant economic burden.

In addition, a CAH must have an agreement with its designated OPO and with at least one tissue bank and at least one eye bank. CAHs are required under section 1138 of the Act to refer all potential donors to an OPO. Also, the OPO regulation at 42 CFR 486.306 requires, as a qualification for designation as an OPO, that the OPO have a working relationship with at least 75 percent of the hospitals in its service area that participate in the Medicare and Medicaid programs and that have an operating room and the equipment and personnel for retrieving organs. Therefore, some CAHs may already have an agreement with their designated OPO. Although CAHs may need to modify those existing agreements, the need to make modifications would not impose a significant economic burden. Although there is no statutory or regulatory requirement for a CAH to have agreements with tissue and eye banks, we must assume some CAHs have agreements with tissue and eye banks, since hospitals are the source for virtually all tissues and eyes.

The CoP would require CAHs to notify the OPO about every death that occurs in the CAH. The average Medicare hospital has approximately 165 beds and 200 deaths per year. However, by statute and regulation, CAHs may use no more than 15 beds for acute care services. Assuming that the number of deaths in a hospital is related to the number of acute care beds, there should be approximately 18 deaths per year in the average CAH. Thus, the economic impact for a CAH of referring all deaths would be small.

Under the proposed CoP, a CAH may agree to have the OPO determine medical suitability for tissue and eye donation or may have alternative arrangements with a tissue bank and an eye bank. These alternative arrangements could include the CAH's direct notification of the tissue and eye bank of potential tissue and eye donors or direct notification of all deaths. Again, the impact is small, and the regulation permits the CAH to decide how this process will take place. We recognize that many communities already have a one-phone-call system in place. In addition, some OPOs are also tissue banks or eye banks or both. A CAH that chose to use the OPO's tissue and eye bank services in these localities would need to make only one telephone call on every death.

This proposed CoP requires that the individual who initiates a request for

donation to the family of a potential donor must be an OPO representative or a designated requestor. A designated requestor is an individual who has taken a course offered or approved by the OPO in the methodology for approaching families of potential donors and requesting donation. The CAH would need to arrange for designated requestor training. Most OPOs have trained designated requestors as part of the hospital CoP for organ, tissue, and eye procurement. Even if the CAH wants to have a sufficient number of designated requestors to ensure that all shifts are covered, this provision of the regulation would not have a significant economic impact on CAHs. In addition, the CAH may be able to choose to have donation requests initiated by the OPO, the tissue bank, or the eye bank staff rather than CAH staff, in which case there is no economic impact.

The regulation requires a CAH to work cooperatively with the OPO, a tissue bank, and an eye bank in educating CAH staff. We do not believe education of CAH staff will demand a significant amount of staff time. In addition, most OPOs already give educational presentations for the staff in their hospitals.

The regulation requires a CAH to work cooperatively with the OPO, a tissue bank, and an eye bank in reviewing death records. Most OPOs currently conduct extensive CAH death record reviews. The CAH's assistance is required only to provide lists of CAH deaths and facilitate access to records.

Finally, the regulation requires a CAH to work cooperatively with the OPO, a tissue bank, and an eye bank in maintaining potential donors while necessary testing and placement of potential donated organs and tissues take place. It is possible that because of the proposed CoP, some CAHs may have their first organ donors. Therefore, we considered the impact on a CAH of maintaining a brain dead potential donor on a ventilator until the organs can be placed. CAHs with full ventilator capability should have no trouble maintaining a potential donor until the organs are placed. However, some CAHs have ventilator capability only so that a patient can be maintained until he or she is transferred to a larger facility for treatment. These CAHs would have the equipment and staffing to maintain a potential donor until transfer to another facility occurs. Some CAHs do not have ventilator capability and would be unable to maintain a potential donor. However, CAHs without ventilator capability would still be obligated to notify the OPO, or a third party designated by the OPO, of all individuals whose death is imminent or who have died in the CAH because there is a potential to obtain a tissue or an eye donation. We do not believe there will be a significant impact on CAHs no matter what their situation—full ventilator capability, ventilator capability only for patients who are to be transferred to a larger facility, or no ventilator capability.

We are sensitive to the possible burden this proposed CoP may place on CAHs. Therefore, we are particularly interested in comments and information concerning the previously mentioned requirements.

IX. Impact of Proposed Changes in the Capital Prospective Payment System

A. General Considerations

We now have cost report data for the 7th year of the capital prospective payment system (cost reports beginning in FY 1998) available through the December 1999 update of the HCRIS. We also have updated information on the projected aggregate amount of obligated capital approved by the fiscal intermediaries. However, our impact analysis of payment changes for capital-related costs is still limited by the lack of hospital-specific data on several items. These are the hospital's projected new capital costs for each year, its projected old capital costs for each year, and the actual amounts of obligated capital that will be put in use for patient care and recognized as Medicare old capital costs in each year. The lack of this information affects our impact analysis in the following ways:

- Major investment in hospital capital assets (for example, in building and major fixed equipment) occurs at irregular intervals. As a result, there can be significant variation in the growth rates of Medicare capital-related costs per case among hospitals. We do not have the necessary hospital-specific budget data to project the hospital capital growth rate for individual hospitals.
- Our policy of recognizing certain obligated capital as old capital makes it difficult to project future capital-related costs for individual hospitals. Under § 412.302(c), a hospital is required to notify its intermediary that it has obligated capital by the later of October 1, 1992, or 90 days after the beginning of the hospital's first cost reporting period under the capital prospective payment system. The intermediary must then notify the hospital of its determination whether the criteria for recognition of obligated capital have been met by the later of the end of the hospital's first cost reporting period subject to the capital prospective payment system or 9 months after the receipt of the hospital's notification. The amount that is recognized as old capital is limited to the lesser of the actual allowable costs when the asset is put in use for patient care or the estimated costs of the capital expenditure at the time it was obligated. We have substantial information regarding fiscal intermediary determinations of projected aggregate obligated capital amounts. However, we still do not know when these projects will actually be put into use for patient care, the actual amount that will be recognized as obligated capital when the project is put into use, or the Medicare share of the recognized costs. Therefore, we do not know actual obligated capital commitments for purposes of the FY 2001 capital cost projections. In Appendix B of this proposed rule, we discuss the assumptions and computations that we employ to generate the amount of obligated capital commitments for use in the FY 2001 capital cost projections.

In Table III of this section, we present the redistributive effects that are expected to occur between ''hold-harmless'' hospitals and ''fully prospective'' hospitals in FY 2001. In addition, we have integrated sufficient hospital-specific information into our actuarial model to project the impact of the proposed FY 2001 capital payment policies by the standard prospective payment system hospital groupings. While we now have actual information on the effects of the transition payment methodology and interim payments under the capital prospective payment system and cost report data for most hospitals, we still need to randomly generate numbers for the change in old capital costs, new capital costs for each year, and obligated amounts that will be put in use for patient care services and recognized as old capital each year. We continue to be unable to predict accurately FY 2001 capital costs for individual hospitals, but with the most recent data on hospitals' experience under the capital prospective payment system, there is adequate information to estimate the aggregate impact on most hospital groupings.

B. Projected Impact Based on the Proposed FY 2001 Actuarial Model

1. Assumptions

In this impact analysis, we model dynamically the impact of the capital prospective payment system from FY 2000 to FY 2001 using a capital cost model. The FY 2001 model, as described in Appendix B of this proposed rule, integrates actual data from individual hospitals with randomly generated capital cost amounts. We have capital cost data from cost reports beginning in FY 1989 through FY 1998 as reported on the December 1999 update of HCRIS, interim payment data for hospitals already receiving capital prospective payments through PRICER, and data reported by the intermediaries that include the hospital-specific rate determinations that have been made through January 1, 2000 in the provider-specific file. We used these data to determine the proposed FY 2001 capital rates. However, we do not have individual hospital data on old capital changes, new capital formation, and actual obligated capital costs. We have data on costs for capital in use in FY 1998, and we age that capital by a formula described in Appendix B. Therefore, we need to randomly generate only new capital acquisitions for any year after FY 1998. All Federal rate payment parameters are assigned to the applicable hospital.

For purposes of this impact analysis, the proposed FY 2001 actuarial model includes the following assumptions:

- Medicare inpatient capital costs per discharge will change at the following rates during these periods:

AVERAGE PERCENTAGE CHANGE IN CAPITAL COSTS PER DISCHARGE

Fiscal year	Percentage change
1999	3.16
2000	2.34
2001	1.99

- We estimate that the Medicare case-mix index will increase by 0.5 percent in FY 2000 and in FY 2001.

• The Federal capital rate and the hospital-specific rate were updated in FY 1996 by an analytical framework that considers changes in the prices associated with capital-related costs and adjustments to account for forecast error, changes in the case-mix index, allowable changes in intensity, and other factors. The proposed FY 2001 update is 0.9 percent (see section IV. of the Addendum to this proposed rule).

2. Results

We have used the actuarial model to estimate the change in payment for capital-related costs from FY 2000 to FY 2001. Table III shows the effect of the capital prospective payment system on low capital cost hospitals and high capital cost hospitals. We consider a hospital to be a low capital cost hospital if, based on a comparison of its initial hospital-specific rate and the applicable Federal rate, it will be paid under the fully prospective payment methodology. A high capital cost hospital is a hospital that, based on its initial hospital-specific rate and the applicable Federal rate, will be paid under the hold-harmless payment methodology. Based on our actuarial model, the breakdown of hospitals is as follows:

CAPITAL TRANSITION PAYMENT METHODOLOGY FOR FY 2001

Type of hospital	Percent of hospitals	Percent of discharges	Percent of capital costs	Percent of capital payments
Low Cost Hospital	67	62	56	61
High Cost Hospital	33	38	44	39

A low capital cost hospital may request to have its hospital-specific rate redetermined based on old capital costs in the current year, through the later of the hospital's cost reporting period beginning in FY 1994 or the first cost reporting period beginning after obligated capital comes into use (within the limits established in § 412.302(e) for putting obligated capital into use for patient care). If the redetermined hospital-specific rate is greater than the adjusted Federal rate, these hospitals will be paid under the hold-harmless payment methodology. Regardless of whether the hospital became a hold-harmless payment hospital as a result of a redetermination, we continue to show these hospitals as low capital cost hospitals in Table III.

Assuming no behavioral changes in capital expenditures, Table III displays the percentage change in payments from FY 2000 to FY 2001 using the above described actuarial model. With the proposed Federal rate, we estimate aggregate Medicare capital payments will increase by 5.89 percent in FY 2001. This increase is noticeably higher than last year's (3.34 percent) due to the combination of the increase in the number of hospital admissions, the increase in case-mix, and the increase in the Federal blend percentage from 90 percent to 100 percent and a decrease in the hospital-specific rate percentage from 10 percent to 0 percent for fully prospective payment hospitals.

TABLE III.—IMPACT OF PROPOSED CHANGES FOR FY 2001 ON PAYMENTS PER DISCHARGE

	Number of Hospitals	Discharges	Adjusted Federal payment	Average Federal percent	Hospital specific payment	Hold harmless payment	Exceptions payment	Total payment	Percent Change over FY 2000
FY 2000 Payments per Discharge									
Low Cost Hospitals	3,187	6,757,956	$581.11	90.42	$30.20	$2.40	$8.90	$622.61	.....
Fully Prospective	3,015	6,289,996	577.57	90.00	32.44	.....	8.52	618.53	.....
100% Federal Rate	155	430,322	638.22	100.00	.....	.....	3.76	641.98	.....
Hold Harmless	17	37,639	520.20	60.95	.....	431.53	130.53	1,082.26	.....
High Cost Hospitals	1,588	4,091,922	658.45	97.93	.....	19.44	13.10	690.98	.....
100% Federal Rate	1,394	3,742,341	676.37	100.00	.....	.....	9.01	685.38	.....
Hold Harmless	194	349,581	466.63	74.15	.....	227.51	56.83	750.97	.....
Total Hospitals	4,775	10,849,879	610.28	93.33	18.81	8.83	10.48	648.40	.....
FY 2001 Payments per Discharge									
Low Cost Hospitals	3,187	6,869,437	$649.67	99.81	.....	$1.74	$10.12	$661.54	6.25
Fully Prospective	3,015	6,393,759	650.22	100.00	.....	.....	9.55	659.77	6.67
100% Federal Rate	157	442,002	648.25	100.00	.....	.....	4.59	652.84	1.69
Hold Harmless	15	33,676	564.26	68.97	.....	355.91	191.29	1,111.46	2.70
High Cost Hospitals	1,588	4,159,343	666.60	98.79	.....	12.23	19.53	698.36	1.07
100% Federal Rate	1,412	3,853,508	680.13	100.00	.....	.....	13.37	693.50	1.19
Hold Harmless	176	305,834	496.05	81.77	.....	166.38	97.07	759.50	1.14
Total Hospitals	4,775	11,028,780	656.05	99.42	.....	5.70	13.67	675.42	4.17

We project that low capital cost hospitals paid under the fully prospective payment methodology will experience an average increase in payments per case of 6.67 percent, and high capital cost hospitals will experience an average increase of 1.07 percent. These results are due to the change in the blended percentages to the payment system to 100 percent adjusted Federal rate and 0 percent hospital-specific rate.

For hospitals paid under the fully prospective payment methodology, the Federal rate payment percentage will increase from 90 percent to 100 percent and the hospital-specific rate payment percentage will decrease from 10 to 0 percent in FY 2001. The Federal rate payment percentage for hospitals paid under the hold-harmless payment methodology is based on the hospital's ratio of new capital costs to total capital costs. The average Federal rate payment percentage for high cost hospitals receiving a hold-harmless payment for old capital will increase from 74.15 percent to 81.77 percent. We estimate the percentage of hold-harmless hospitals paid based on 100

percent of the Federal rate will increase from 87.78 percent to 88.92 percent. We estimate that the few remaining high cost hold-harmless hospitals (176) will experience an increase in payments of 1.14 percent from FY 2000 to FY 2001. This increase reflects our estimate that exception payments per discharge will increase 70.81 percent from FY 2000 to FY 2001 for high cost hold-harmless hospitals. While we estimate that this group's regular hold-harmless payments for old capital will decline by 26.87 percent due to the retirement of old capital, we estimate that its high overall capital costs will cause an increase in these hospitals' exceptions payments from $56.83 per discharge in FY 2000 to $97.07 per discharge in FY 2001. This is primarily due to the estimated decrease in outlier payments, which will cause an estimated increase in exceptions payments to cover unmet capital costs.

We expect that the average hospital-specific rate payment per discharge will decrease from $32.44 in FY 2000 to $0.00 in FY 2001. This decrease is due to the decrease in the hospital-specific rate payment percentage from 10 percent in FY 2000 to 0 percent in FY 2001 for fully prospective payment hospitals.

We are proposing no changes in our exceptions policies for FY 2001. As a result, the minimum payment levels would be—

- 90 percent for sole community hospitals;
- 80 percent for urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or more; or
- 70 percent for all other hospitals.

We estimate that exceptions payments will increase from 1.62 percent of total capital payments in FY 2000 to 2.02 percent of payments in FY 2001. The projected distribution of the exception payments is shown in the chart below:

ESTIMATED FY 2001 EXCEPTIONS PAYMENTS

Type of hospital	Number of hospitals	Percent of exceptions payments
Low Capital Cost	186	46
High Capital Cost	191	54
Total	377	100

C. Cross-Sectional Comparison of Capital Prospective Payment Methodologies

Table IV presents a cross-sectional summary of hospital groupings by capital prospective payment methodology. This distribution is generated by our actuarial model.

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TABLE IV.— DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS-ESTIMATE FOR FY 2001 PAYMENTS

	(1) Total No. of Hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
By Geographic Location:				
All hospitals	4,775	4.0	32.9	63.1
Large urban areas (populations over 1 million)	1,514	4.0	41.1	55.0
Other urban areas (populations of 1 million of fewer)	1,144	4.8	40.6	54.5
Rural areas	2,117	3.6	22.8	73.6
Urban hospitals	2,658	4.3	40.9	54.8
0-99 beds	646	5.9	33.7	60.4
100-199 beds	918	5.7	47.2	47.2
200-299 beds	542	3.7	41.9	54.4
300-499 beds	410	0.5	37.3	62.2
500 or more beds	142	2.1	39.4	58.5
Rural hospitals	2,117	3.6	22.8	73.6
0-49 beds	1,201	3.0	16.4	80.6
50-99 beds	547	4.8	28.2	67.1
100-149 beds	217	5.1	35.0	59.9
150-199 beds	85	2.4	28.2	69.4
200 or more beds	67	1.5	46.3	52.2
By Region:				
Urban by Region	2,658	4.3	40.9	54.8
New England	145	0.7	25.5	73.8
Middle Atlantic	407	2.7	34.6	62.7
South Atlantic	395	5.1	52.2	42.8
East North Central	453	3.8	30.2	66.0
East South Central	153	7.2	47.7	45.1
West North Central	180	5.6	37.2	57.2
West South Central	326	9.5	57.4	33.1
Mountain	123	2.4	52.0	45.5
Pacific	431	2.6	37.6	59.9
Puerto Rico	45	0.0	28.9	71.1
Rural by Region	2,117	3.6	22.8	73.6
New England	52	0.0	21.2	78.8
Middle Atlantic	78	3.8	20.5	75.6
South Atlantic	276	1.4	34.1	64.5
East North Central	280	2.5	17.9	79.6
East South Central	265	3.0	33.2	63.8
West North Central	489	3.1	14.5	82.4
West South Central	333	4.5	26.1	69.4
Mountain	200	8.5	16.0	75.5
Pacific	139	5.0	23.7	71.2
By Payment Classification:				
Large urban areas (populations over 1 million)	1,586	3.8	41.1	55.0
Other urban areas (populations of 1 million of fewer)	1,148	4.9	40.2	55.0
Rural areas	2,041	3.6	22.3	74.0
Teaching Status:				
Non-teaching	3,670	4.4	32.2	63.3
Fewer than 100 Residents	869	2.9	35.6	61.6
100 or more Residents	236	1.3	32.6	66.1
Disproportionate share hospitals (DSH):				
Non-DSH	2,974	4.1	28.6	67.2
Urban DSH:				
100 or more beds	1,371	3.8	43.3	53.0
Less than 100 beds	74	5.4	25.7	68.9
Rural DSH:				
Sole Community (SCH/EACH)	153	5.2	22.2	72.5
Referral Center (RRC/EACH)	54	1.9	53.7	44.4

TABLE IV.— DISTRIBUTION BY METHOD OF PAYMENT (HOLD-HARMLESS/FULLY PROSPECTIVE) OF HOSPITALS RECEIVING CAPITAL PAYMENTS-ESTIMATE FOR FY 2001 PAYMENTS

	(1) Total No. of Hospitals	(2) Hold-harmless		(3) Percentage paid fully prospective rate
		Percentage paid hold-harmless (A)	Percentage paid fully federal (B)	
Other Rural:				
100 or more beds	48	2.1	41.7	56.3
Less than 100 beds	101	2.0	21.8	76.2
Urban teaching and DSH:				
Both teaching and DSH	715	2.0	36.8	61.3
Teaching and no DSH	325	3.7	32.9	63.4
No teaching and DSH	730	5.8	47.8	46.4
No teaching and no DSH	964	5.1	40.9	54.0
Rural Hospital Types:				
Non special status hospitals	822	1.3	24.3	74.3
RRC/EACH	150	1.3	38.0	60.7
SCH/EACH	660	7.7	19.4	72.9
Medicare-dependent hospitals (MDH)	351	1.4	16.0	82.6
SCH, RRC and EACH	58	8.6	25.9	65.5
Type of Ownership:				
Voluntary	2,804	3.6	32.1	64.3
Proprietary	736	6.8	57.9	35.3
Government	1,211	3.4	19.9	76.7
Medicare Utilization as a Percent of Inpatient Days:				
0-25	366	4.4	28.1	67.5
25-50	1,818	3.9	35.3	60.8
50-65	1,882	4.1	31.8	64.1
Over 65	685	3.9	32.7	63.4

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As we explain in Appendix B of this proposed rule, we were not able to use 61 of the 4,836 hospitals in our database due to insufficient (missing or unusable) data. Consequently, the payment methodology distribution is based on 4,775 hospitals. These data should be fully representative of the payment methodologies that will be applicable to hospitals.

The cross-sectional distribution of hospital by payment methodology is presented by: (1) Geographic location; (2) region; and (3) payment classification. This provides an indication of the percentage of hospitals within a particular hospital grouping that will be paid under the fully prospective payment methodology and the hold-harmless payment methodology.

The percentage of hospitals paid fully Federal (100 percent of the Federal rate) as hold-harmless hospitals is expected to increase to 32.9 percent in FY 2001.

Table IV indicates that 63.1 percent of hospitals will be paid under the fully prospective payment methodology. (This figure, unlike the figure of 67 percent for low cost capital hospitals in the chart on ''Capital Transition Payment Methodology for FY 2001,'' in section VII.B.2. of this impact analysis takes into account the effects of redeterminations. In other words, this figure does not include low cost hospitals that, following a hospital-specific rate redetermination, are now paid under the hold-harmless methodology.) As expected, a relatively higher percentage of rural and governmental hospitals (74.0 percent and 76.7 percent, respectively by payment classification) are being paid under the fully prospective payment methodology. This is a reflection of their lower than average capital costs per case. In contrast, only 35.3 percent of proprietary hospitals are being paid under the fully prospective methodology. This is a reflection of their higher than average capital costs per case. (We found at the time of the August 30, 1991 final rule (56 FR 43430) that 62.7 percent of proprietary hospitals had a capital cost per case above the national average cost per case.)

D. Cross-Sectional Analysis of Changes in Aggregate Payments

We used our FY 2001 actuarial model to estimate the potential impact of our proposed changes for FY 2001 on total capital payments per case, using a universe of 4,775 hospitals. The individual hospital payment parameters are taken from the best available data, including: the January 1, 2000 update to the provider-specific file, cost report data, and audit information supplied by intermediaries. In Table V we present the results of the cross-sectional analysis using the results of our actuarial model and the aggregate impact of the proposed FY 2001 payment policies. Columns 3 and 4 show estimates of payments per case under our model for FY 2000 and FY 2001. Column 5 shows the total percentage change in payments from FY 2000 to FY 2001. Column 6 presents the percentage change in payments that can be attributed to Federal rate changes alone.

Federal rate changes represented in Column 6 include the 1.60 percent increase in the Federal rate, a 0.5 percent increase in case mix, changes in the adjustments to the Federal rate (for example, the effect of the new hospital wage index on the geographic adjustment factor), and reclassifications by the MGCRB. Column 5 includes the effects of the Federal rate changes represented in Column 6. Column 5 also reflects the effects of all other changes, including the change from 90 percent to 100 percent in the portion of the Federal rate for fully prospective hospitals, the hospital-specific rate update, changes in the proportion of new to total capital for hold-harmless hospitals, changes in old capital (for example, obligated capital put in use), hospital-specific rate redeterminations, and exceptions. The comparisons are provided by: (1) Geographic location, (2) region, and (3) payment classification.

The simulation results show that, on average, capital payments per case can be expected to increase 4.2 percent in FY 2001. The results show that the effect of the Federal rate change alone is to increase payments by 0.9 percent. In addition to the increase attributable to the Federal rate change, a 3.3 percent increase is attributable to the effects of all other changes.

Our comparison by geographic location shows an overall increase in payments to hospitals in all areas. This comparison also shows that urban and rural hospitals will experience slightly different rates of increase in capital payments per case (3.9 percent and 5.9 percent, respectively). This difference is due to the lower rate of increase for urban hospitals relative to rural hospitals (0.6 percent and 2.7 percent, respectively) from the Federal rate changes alone. Urban hospitals will gain approximately the same as rural hospitals (3.3 percent versus 3.2 percent, respectively) from the effects of all other changes.

All regions are estimated to receive increases in total capital payments per case, partly due to the increased share of payments that are based on the Federal rate (from 90 to 100 percent). Changes by region vary from a minimum of 2.6 percent increase (Middle Atlantic urban region) to a maximum of 7.5 percent increase (East North Central rural region).

By type of ownership, government hospitals are projected to have the largest rate of increase of total payment changes (5.6 percent, a 1.4 percent increase due to the Federal rate changes, and a 4.2 percent increase from the effects of all other changes). Payments to voluntary hospitals will increase 4.0 percent (a 0.9 percent increase due to Federal rate changes, and a 3.1 percent increase from the effects of all other changes) and payments to proprietary hospitals will increase 3.6 percent (a 0.4 percent increase due to Federal rate changes, and a 3.2 percent increase from the effects of all other changes).

Section 1886(d)(10) of the Act established the MGCRB. Hospitals may apply for reclassification for purposes of the standardized amount, wage index, or both and for purposes of DSH for FYs 1999 through 2001. Although the Federal capital rate is not affected, a hospital's geographic classification for purposes of the operating standardized amount does affect a hospital's capital payments as a result of the large urban adjustment factor and the disproportionate share adjustment for urban hospitals with 100 or more beds. Reclassification for wage index purposes affects the geographic adjustment factor, since that factor is constructed from the hospital wage index.

To present the effects of the hospitals being reclassified for FY 2001 compared to the effects of reclassification for FY 2000, we show the average payment percentage increase for hospitals reclassified in each fiscal year and in total. For FY 2001 reclassifications, we indicate those hospitals reclassified for standardized amount purposes only, for wage index purposes only, and for both purposes. The reclassified groups are compared to all other nonreclassified hospitals. These categories are further identified by urban and rural designation.

Hospitals reclassified for FY 2001 as a whole are projected to experience a 5.9 percent increase in payments (a 2.4 percent increase attributable to Federal rate changes and a 3.5 percent increase attributable to the effects of all other changes). Payments to nonreclassified hospitals will increase slightly less (4.2 percent) than reclassified hospitals (5.9 percent) overall. Payments to nonreclassified hospitals will increase less than reclassified hospitals from the Federal rate changes (0.9 percent compared to 2.4 percent), but they will gain about the same from the effects of all other changes (3.3 percent compared to 3.5 percent).

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE (FY 2000 PAYMENTS COMPARED TO FY 2001 PAYMENTS)

	Number of Hospitals	Average FY 2000 pay-ments/case	Average FY 2001 pay-ments/case	All Changes	Portion Attributable to Federal Rate Change
By Geographic Location:					
All hospitals	4,775	648	675	4.2	0.9
Large urban areas (populations over 1 million)	1,514	752	779	3.5	0.2
Other urban areas (populations of 1 million of fewer)	1,144	639	667	4.4	1.1
Rural areas	2,117	434	460	5.9	2.7
Urban hospitals	2,658	703	730	3.9	0.6
0-99 beds	646	503	525	4.3	1.3
100-199 beds	918	613	635	3.7	0.9
200-299 beds	542	671	697	4.0	0.7
300-499 beds	410	731	761	4.1	0.4
500 or more beds	142	912	944	3.6	0.2
Rural hospitals	2,117	434	460	5.9	2.7
0-49 beds	1,201	360	386	7.4	3.6
50-99 beds	547	408	432	5.9	2.8
100-149 beds	217	453	476	5.2	2.4
150-199 beds	85	473	501	6.0	2.7
200 or more beds	67	535	564	5.4	2.2
By Region:					
Urban by Region	2,658	703	730	3.9	0.6
New England	145	727	764	5.0	1.0
Middle Atlantic	407	772	793	2.6	-0.2
South Atlantic	395	682	705	3.4	0.7
East North Central	453	678	710	4.7	0.9
East South Central	153	645	664	2.9	-0.8
West North Central	180	694	727	4.7	1.2
West South Central	326	668	695	4.2	1.1
Mountain	123	672	703	4.6	1.0
Pacific	431	794	830	4.6	0.6
Puerto Rico	45	290	304	4.7	2.1
Rural by Region	2,117	434	460	5.9	2.7
New England	52	516	539	4.5	1.5
Middle Atlantic	78	460	487	6.1	2.5
South Atlantic	276	447	473	5.8	2.9
East North Central	280	444	478	7.5	3.0
East South Central	265	398	422	5.9	2.4
West North Central	489	425	448	5.5	3.0
West South Central	333	392	410	4.7	2.4
Mountain	200	458	482	5.3	3.0
Pacific	139	508	543	7.0	3.1
By Payment Classification:					
All hospitals	4,775	648	675	4.2	0.9
Large urban areas (populations over 1 million)	1,586	745	772	3.5	0.3
Other urban areas (populations of 1 million of fewer)	1,148	638	666	4.5	1.1
Rural areas	2,041	430	456	5.9	2.7
Teaching Status:					
Non-teaching	3,670	537	558	4.0	1.3
Fewer than 100 Residents	869	678	710	4.7	0.9
100 or more Residents	236	993	1,029	3.6	-0.1
Urban DSH:					
100 or more beds	1,371	743	773	4.0	0.6
Less than 100 beds	74	519	520	0.0	1.2
Rural DSH:					
Sole Community (SCH/EACH)	153	376	411	9.2	3.9
Referral Center (RRC/EACH)	54	494	512	3.5	1.3
Other Rural:					
100 or more beds	48	390	410	5.0	3.2
Less than 100 beds	101	346	372	7.5	3.9

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE
(FY 2000 PAYMENTS COMPARED TO FY 2001 PAYMENTS)

	Number of Hospitals	Average FY 2000 payments/case	Average FY 2001 payments/case	All Changes	Portion Attributable to Federal Rate Change
Urban teaching and DSH:					
Both teaching and DSH	715	816	849	4.1	0.5
Teaching and no DSH	325	708	740	4.5	0.5
No teaching and DSH	730	615	637	3.7	0.9
No teaching and no DSH	964	573	591	3.1	0.7
Rural Hospital Types:					
Non special status hospitals	822	382	406	6.3	3.3
RRC/EACH	150	499	525	5.3	2.1
SCH/EACH	660	421	451	7.0	2.8
Medicare-dependent hospitals (MDH)	351	358	387	8.0	3.5
SCH, RRC and EACH	58	523	539	3.1	1.8
Hospitals Reclassified by the Medicare Geographic Classification Review Board:					
Reclassification Status During FY00 and FY01:					
Reclassified During Both FY00 and FY01	381	550	575	4.6	1.3
Reclassified During FY01 Only	160	555	610	9.9	5.8
Reclassified During FY00 Only	144	568	567	-0.1	-2.8
FY01 Reclassifications:					
All Reclassified Hospitals	541	552	584	5.9	2.4
All Nonreclassified Hospitals	4,251	661	689	4.2	0.9
All Urban Reclassified Hospitals	93	719	760	5.7	1.4
Urban Nonreclassified Hospitals	2,540	703	730	3.8	0.5
All Reclassified Rural Hospitals	448	491	521	6.0	2.9
Rural Nonreclassified Hospitals	1,668	389	412	5.9	2.6
Other Reclassified Hospitals (Section 1886(D)(8)(B))	26	478	492	2.9	0.8

TABLE V.—COMPARISON OF TOTAL PAYMENTS PER CASE
(FY 2000 PAYMENTS COMPARED TO FY 2001 PAYMENTS)

	Number of Hospitals	Average FY 2000 payments/case	Average FY 2001 payments/case	All Changes	Portion Attributable to Federal Rate Change
Type of Ownership:					
Voluntary	2,804	663	690	4.0	0.9
Proprietary	736	631	654	3.6	0.4
Government	1,211	580	612	5.6	1.4
Medicare Utilization as a Percent of Inpatient Days:					
0-25	366	805	853	6.0	0.6
25-50	1,818	743	771	3.8	0.5
50-65	1,882	578	603	4.4	1.2

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Appendix B: Technical Appendix on the Capital Cost Model and Required Adjustments

Under section 1886(g)(1)(A) of the Act, we set capital prospective payment rates for FY 1992 through FY 1995 so that aggregate prospective payments for capital costs were projected to be 10 percent lower than the amount that would have been payable on a reasonable cost basis for capital-related costs in that year. To implement this requirement, we developed the capital acquisition model to determine the budget neutrality adjustment factor. Even though the budget neutrality requirement expired effective with FY 1996, we must continue to determine the recalibration and geographic reclassification budget neutrality adjustment factor and the reduction in the Federal and hospital-specific rates for exceptions payments. To determine these factors, we must continue to project capital costs and payments.

We used the capital acquisition model from the start of prospective payments for capital costs through FY 1997. We now have 7 years of cost reports under the capital prospective payment system. For FY 1998, we developed a new capital cost model to replace the capital acquisition model. This revised model makes use of the data from these cost reports.

The following cost reports are used in the capital cost model for this proposed rule: The December 31, 1999 update of the cost reports for PPS–IX (cost reporting periods beginning in FY 1992), PPS–X (cost reporting periods beginning in FY 1993), PPS–XI (cost reporting periods beginning in FY 1994), PPS–XII (cost reporting periods beginning in FY 1995), PPS–XIII (cost reporting periods beginning in FY 1996), PPS–XIV (cost reporting periods beginning in FY 1997), and PPS–XV (cost reporting periods beginning in FY 1998). In addition, to model payments, we use the January 1, 2000 update of the provider-specific file, and the March 1994 update of the intermediary audit file.

Since hospitals under alternative payment system waivers (that is, hospitals in Maryland) are currently excluded from the capital prospective payment system, we excluded these hospitals from our model.

We developed FY 1992 through FY 2000 hospital-specific rates using the provider-specific file and the intermediary audit file.

(We used the cumulative provider-specific file, which includes all updates to each hospital's records, and chose the latest record for each fiscal year.) We checked the consistency between the provider-specific file and the intermediary audit file. We ensured that increases in the hospital-specific rates were at least as large as the published updates (increases) for the hospital-specific rates each year. We were able to match hospitals to the files as shown in the following table:

Source	Number of hospitals
Provider-Specific File Only	129
Provider-Specific and Audit File	4,707
Total	4,836

Eighty-two of the 4,836 hospitals had unusable or missing data, or had no cost reports available. For 20 of the 82 hospitals, we were unable to determine a hospital-specific rate from the available cost reports. However, there was adequate cost information to determine that these hospitals were paid under the hold-harmless methodology. Since the hospital-specific rate is not used to determine payments for hospitals paid under the hold-harmless methodology, there was sufficient cost report information available to include these 20 hospitals in the analysis. We were able to estimate hospital-specific amounts for one additional hospital from the PPS–IX cost reports. Hence we were able to use 21 of the 82 hospitals. We used 4,775 hospitals for the analysis. Sixty-one hospitals could not be used in the analysis because of insufficient information. These hospitals account for less than 0.7 percent of admissions. Therefore, any effects from the elimination of their cost report data should be minimal.

We analyzed changes in capital-related costs (depreciation, interest, rent, leases, insurance, and taxes) reported in the cost reports. We found a wide variance among hospitals in the growth of these costs. For hospitals with more than 100 beds, the distribution and mean of these cost increases were different for large changes in bed-size (greater than ±20 percent). We also analyzed changes in the growth in old capital and new capital for cost reports that provided this information. For old capital, we limited the analysis to decreases in old capital. We did this since the opportunity for most hospitals to treat ''obligated'' capital put into service as old capital has expired. Old capital costs should decrease as assets become fully depreciated and as interest costs decrease as the loan is amortized.

The new capital cost model separates the hospitals into three mutually exclusive groups. Hold-harmless hospitals with data on old capital were placed in the first group. Of the remaining hospitals, those hospitals with fewer than 100 beds comprise the second group. The third group consists of all hospitals that did not fit into either of the first two groups. Each of these groups displayed unique patterns of growth in capital costs. We found that the gamma distribution is useful in explaining and describing the patterns of increase in capital costs. A gamma distribution is a statistical distribution that can be used to describe patterns of growth rates, with the greatest proportion of rates being at the low end. We use the gamma distribution to estimate individual hospital rates of increase as follows:

(1) For hold-harmless hospitals, old capital cost changes were fitted to a truncated gamma distribution, that is, a gamma distribution covering only the distribution of cost decreases. New capital costs changes were fitted to the entire gamma distribution, allowing for both decreases and increases.

(2) For hospitals with fewer than 100 beds (small), total capital cost changes were fitted to the gamma distribution, allowing for both decreases and increases.

(3) Other (large) hospitals were further separated into three groups:

- Bed-size decreases over 20 percent (decrease).
- Bed-size increases over 20 percent (increase).
- Other (no change).

Capital cost changes for large hospitals were fitted to gamma distributions for each bed-size change group, allowing for both decreases and increases in capital costs. We analyzed the probability distribution of increases and decreases in bed size for large hospitals. We found the probability somewhat dependent on the prior year change in bed size and factored this dependence into the analysis. Probabilities of bed-size change were determined. Separate sets of probability factors were calculated to reflect the dependence on prior year change in bed size (increase, decrease, and no change).

The gamma distributions were fitted to changes in aggregate capital costs for the entire hospital. We checked the relationship between aggregate costs and Medicare per discharge costs. For large hospitals, there was a small variance, but the variance was larger for small hospitals. Since costs are used only for the hold-harmless methodology and to determine exceptions, we decided to use the gamma distributions fitted to aggregate cost increases for estimating distributions of cost per discharge increases.

Capital costs per discharge calculated from the cost reports were increased by random numbers drawn from the gamma distribution to project costs in future years. Old and new capital were projected separately for hold-harmless hospitals. Aggregate capital per discharge costs were projected for all other hospitals. Because the distribution of increases in capital costs varies with changes in bed size for large hospitals, we first projected changes in bed size for large hospitals before drawing random numbers from the gamma distribution. Bed-size changes were drawn from the uniform distribution with the probabilities dependent on the previous year bed-size change. The gamma distribution has a shape parameter and a scaling parameter. (We used different parameters for each hospital group, and for old and new capital.)

We used discharge counts from the cost reports to calculate capital cost per discharge. To estimate total capital costs for FY 1999 (the MedPAR data year) and later, we use the number of discharges from the MedPAR data. Some hospitals had considerably more discharges in FY 1999 than in the years for which we calculated cost per discharge from the cost report data. Consequently, a hospital with few cost report discharges would have a high capital cost per discharge, since fixed costs would be allocated over only a few discharges. If discharges increase substantially, the cost per discharge would decrease because fixed costs would be allocated over more discharges. If the projection of capital cost per discharge is not adjusted for increases in discharges, the projection of exceptions would be overstated. We address this situation by recalculating the cost per discharge with the MedPAR discharges if the MedPAR discharges exceed the cost report discharges by more than 20 percent. We do not adjust for increases of less than 20 percent because we have not received all of the FY 1999 discharges, and we have removed some discharges from the analysis because they are statistical outliers. This adjustment reduces our estimate of exceptions payments, and consequently, the reduction to the Federal rate for exceptions is smaller. We will continue to monitor our modeling of exceptions payments and make adjustments as needed.

The average national capital cost per discharge generated by this model is the combined average of many randomly generated increases. This average must equal the projected average national capital cost per discharge, which we projected separately (outside this model). We adjusted the shape parameter of the gamma distributions so that the modeled average capital cost per discharge matches our projected capital cost per discharge. The shape parameter for old capital was not adjusted since we are modeling the aging of ''existing'' assets. This model provides a distribution of capital costs among hospitals that is consistent with our aggregate capital projections.

Once each hospital's capital-related costs are generated, the model projects capital payments. We use the actual payment parameters (for example, the case-mix index and the geographic adjustment factor) that are applicable to the specific hospital.

To project capital payments, the model first assigns the applicable payment methodology (fully prospective or hold-harmless) to the hospital as determined from the provider-specific file and the cost reports. The model simulates Federal rate payments using the assigned payment parameters and hospital-specific estimated outlier payments. The case-mix index for a hospital is derived from the FY 1999 MedPAR file using the FY 2001 DRG relative weights included in section VI. of the Addendum to this proposed rule. The case-mix index is increased each year after FY 1999 based on analysis of past experiences in case-mix increases. Based on analysis of recent case-mix increases, we estimate that case-mix will increase 0.5 percent in FY 2000. We project that case-mix will increase 0.5 percent in FY 2001. (Since we are using FY 1999 cases for our analysis, the FY 1999 increase in case-mix has no effect on projected capital payments.)

Changes in geographic classification and revisions to the hospital wage data used to establish the hospital wage index affect the geographic adjustment factor. Changes in the DRG classification system and the relative weights affect the case-mix index.

Section 412.308(c)(4)(ii) requires that the estimated aggregate payments for the fiscal year, based on the Federal rate after any changes resulting from DRG reclassifications and recalibration and the geographic adjustment factor, equal the estimated aggregate payments based on the Federal rate that would have been made without such changes. For FY 2000, the budget neutrality adjustment factors were 1.00142 for the national rate and 1.00134 for the Puerto Rico rate.

Since we implemented a separate geographic adjustment factor for Puerto Rico, we applied separate budget neutrality adjustments for the national geographic adjustment factor and the Puerto Rico geographic adjustment factor. We applied the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 and earlier since the geographic adjustment factor for Puerto Rico was implemented in FY 1998.

To determine the factors for FY 2001, we first determined the portions of the Federal national and Puerto Rico rates that would be paid for each hospital in FY 2001 based on its applicable payment methodology. Using our model, we then compared, separately for the national rate and the Puerto Rico rate, estimated aggregate Federal rate payments based on the FY 2000 DRG relative weights and the FY 2000 geographic adjustment factor to estimated aggregate Federal rate payments based on the FY 2000 relative weights and the FY 2001 geographic adjustment factor. In making the comparison, we held the FY 2001 Federal rate portion constant and set the other budget neutrality adjustment factor and the exceptions reduction factor to 1.00. To achieve budget neutrality for the changes in the national geographic adjustment factor, we applied an incremental budget neutrality adjustment of 0.99846 for FY 2001 to the previous cumulative FY 2000 adjustment of 1.00142, yielding a cumulative adjustment of 0.99988 through FY 2001. For the Puerto Rico geographic adjustment factor, we applied an incremental budget neutrality adjustment of 1.00312 for FY 2001 to the previous cumulative FY 2000 adjustment of 1.00134, yielding a cumulative adjustment of 1.00446 through FY 2001. We then compared estimated aggregate Federal rate payments based on the FY 2000 DRG relative weights and the FY 2001 geographic adjustment factors to estimated aggregate Federal rate payments based on the FY 2001 DRG relative weights and the FY 2001 geographic adjustment factors. The incremental adjustment for DRG classifications and changes in relative weights would be 1.00019 nationally and for Puerto Rico. The cumulative adjustments for DRG classifications and changes in relative weights and for changes in the geographic adjustment factors through FY 2001 would be 1.00007 nationally and 1.00465 for Puerto Rico. The following table summarizes the adjustment factors for each fiscal year:

BUDGET NEUTRALITY ADJUSTMENT FOR DRG RECLASSIFICATIONS AND RECALIBRATION AND THE GEOGRAPHIC ADJUSTMENT FACTORS

Fiscal year	National				Puerto Rico			
	Incremental adjustment			Cumulative	Incremental adjustment			Cumulative
	Geographic adjustment factor	DRG reclassifications and recalibration	Combined		Geographic adjustment factor	DRG reclassifications and recalibration	Combined	
1992				1.00000				
1993			0.99800	0.99800				
1994			1.00531	1.00330				
1995			0.99980	1.00310				
1996			0.99940	1.00250				
1997			0.99873	1.00123				
1998			0.99892	1.00015				1.00000
1999	0.99944	1.00335	1.00279	1.00294	0.99898	1.00335	1.00233	1.00233
2000	0.99857	0.99991	0.99848	1.00142	0.99910	0.99991	0.99901	1.00134
2001	0.99846	1.00019	0.99865	1.00007	1.00312	1.00019	1.00331	1.00465

The methodology used to determine the recalibration and geographic (DRG/GAF) budget neutrality adjustment factor is similar to that used in establishing budget neutrality adjustments under the prospective payment system for operating costs. One difference is that, under the operating prospective payment system, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the DRG relative weights. Under the capital prospective payment system, there is a single DRG/GAF budget neutrality adjustment factor (the national rate and the Puerto Rico rate are determined separately) for changes in the geographic adjustment factor (including geographic reclassification) and the DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for serving low-income patients or the large urban add-on payments.

In addition to computing the DRG/GAF budget neutrality adjustment factor, we used the model to simulate total payments under the prospective payment system.

Additional payments under the exceptions process are accounted for through a reduction in the Federal and hospital-specific rates. Therefore, we used the model to calculate the exceptions reduction factor. This exceptions reduction factor ensures that aggregate payments under the capital prospective payment system, including exceptions payments, are projected to equal the aggregate payments that would have been made under the capital prospective payment system without an exceptions process. Since changes in the level of the payment rates change the level of payments under the exceptions process, the exceptions reduction factor must be determined through iteration.

In the August 30, 1991 final rule (56 FR 43517), we indicated that we would publish each year the estimated payment factors generated by the model to determine payments for the next 5 years. The table below provides the actual factors for FYs 1992 through 2000, the proposed factors for FY 2001, and the estimated factors that would be applicable through FY 2005. We caution that these are estimates for FYs 2001 and later, and are subject to revisions resulting from continued methodological refinements, receipt of additional data, and changes in payment policy. We note that in making these projections, we have assumed that the cumulative national DRG/GAF budget neutrality adjustment factor will remain at 1.00007 (1.00465 for Puerto Rico) for FY 2001 and later because we do not have sufficient information to estimate the change that will occur in the factor for years after FY 2001.

The projections are as follows:

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Fiscal Year	Update Factor	Exceptions Reduction Factor	Budget Neutrality Factor	DRG/GAF Adjustment Factor[1]	Outlier Adjustment Factor	Federal Rate Adjustment	Federal Rate (after outlier) reduction)
1992 .	N/A	0.9813	0.9602		.9497		415.59
1993 .	6.07	.9756	.9162	.9980	.9496		417.29
1994 .	3.04	.9485	.8947	1.0053	.9454	.9260[2]	378.34
1995 .	3.44	.9734	.8432	.9998	.9414		376.83
1996 .	1.20	.9849	N/A	.9994	.9536	.9972[3]	461.96
1997 .	0.70	.9358	N/A	.9987	.9481		438.92
1998 .	0.90	.9659	N/A	.9989	.9382	.8222[4]	371.51
1999 .	0.10	.9783	N/A	1.0028	.9392		378.10
2000 .	0.30	.9730	N/A	.9985	.9402		377.03
2001 .	0.90	.9796	N/A	.9987	.9416		383.06
2002 .	0.80	1.0000[6]	N/A	1.0000[5]	.9416[5]		394.17
2003 .	0.70	1.0000[6]	N/A	1.0000	.9416	1.0255[4]	407.07
2004 .	0.70	1.0000[6]	N/A	1.0000	.9416		409.92
2005 .	0.80	1.0000[6]	N/A	1.0000	.9416		413.19

[1]Note: The incremental change over the previous year.

[2]Note: OBRA 1993 adjustment.

[3]Note: Adjustment for change in the transfer policy.

[4]Note: Balanced Budget Act of 1997 adjustment.

[5]Note: Future adjustments are, for purposes of this projection, assumed to remain at the same level.

[6]Note: We are unable to estimate exceptions payments for the year under the special exceptions provision (§ 412.348(g) of the regulations) because the regular exceptions provision (§ 412.348(e)) expires.

APPENDIX C—REPORT TO CONGRESS

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

APR 17 2000

The Honorable Albert Gore, Jr.
President of the Senate
Washington, D.C. 20510

Dear Mr. President:

Section 1886(e)(3) of the Social Security Act (the Act) requires me to report to Congress the initial estimate of the applicable percentage increase in hospital inpatient payment rates for fiscal year (FY) 2001 that I will recommend for hospitals subject to the Medicare prospective payment system (PPS) and for hospitals and units excluded from PPS. This submission constitutes the required report.

Current law mandates, and the President's FY 2001 budget includes, an update for PPS hospitals, except sole community hospitals (SCHs), equal to the market basket minus 1.1 percentage points. The update for SCHs in current law and the President's 2001 budget is equal to the market basket rate of increase. The President's FY 2001 budget estimated the PPS market basket rate of increase for FY 2001 to be 3.2 percent. Based on this estimate, we recommend an update for SCHs of 3.2 percent and for other hospitals in both large urban and other areas of 2.1 percent.

SCHs are the sole source of care in their area and are afforded special payment protection in order to maintain access to services for Medicare beneficiaries. Medicare-dependent, small rural hospitals (MDHs) are a major source of care for Medicare beneficiaries in their area and are afforded special payment protection in order to maintain access to services for beneficiaries. SCHs and MDHs are PPS hospitals. However, SCHs are paid the higher of a hospital-specific rate or the Federal PPS rate, and MDHs are paid the Federal PPS rate, or, if their hospital-specific rate exceeds the Federal PPS rate, the Federal rate plus 50 percent of the difference between the hospital-specific rate and the Federal rate. We recommend an update of 3.2 percent to the SCH hospital-specific rate and 2.1 percent to the MDH hospital-specific rate.

Hospitals and distinct part hospital units excluded from PPS are paid based on their reasonable costs subject to a limit under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Current law mandates that the update for all hospitals and distinct part units excluded from PPS equals the rate of increase in the excluded hospital market basket less a percentage between 0 and 2.5 percentage points, depending on the hospital's costs in relation to its limit, or 0 if costs do not exceed two-thirds of the limit. The President's FY 2001 budget incorporates an increase to the TEFRA limit using